Clinical Reminders

Version 2.0

CLINICIAN GUIDE

April 2005

Health Data Systems
V*IST***A** HSD&D
Department of Veterans Affairs

Table of Contents

Clinical Reminders V. 2.0 and This Guide

Purpose of This Guide

This Clinician Guide is designed to help the clinical practitioner understand Clinical Reminders V. 2.0, and to use the functionality to improve patient care and clinical processes. This guide will also give you an overview of the following national VA reminders/dialogs and components:
VA-Ischemic Heart Disease
VA-Mental Health
VA-GEC Referral
VA-Women's Health/CPRS Integration
MyHealtheVet

Our Target Audience

We have developed this guide for the following individuals, who are responsible for using this package to resolve clinical reminders:

- Clinicians
- Nurses
- Clinical Application Coordinators (CAC)
- Clinical Reminders Managers

Other Sources of Information

Refer to the Web sites listed below when you want to receive more background and technical information about Clinical Reminders V. 2.0.

TIP:

Bookmark these sites for future reference.

Related Documentation

From your Intranet, enter http://www.va.gov/vdl in the Address field to access this manual, and those listed below, from the **V***IST***A** Documentation Library (VDL).

- Clinical Reminders Manager's Manual (PXRM_2_MM.PDF)
- Setup Guide (PXRM_2_SG.PDF)

Other relevant information is also available on the Clinical Reminders website:

http://www.va.gov/reminders

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Introduction

Benefits of Clinical Reminders

"The potential for computerization to improve clinical care has been appreciated for some time. In particular, computerized clinical reminders have been advocated as a strategy to improve compliance with established clinical guidelines. With clinical reminders, the software rather than the human initiates the human–machine interaction. Clinical reminders take advantage of preexisting electronic patient information to alert the provider when an action is recommended. In addition, clinical reminders are ''realtime'' decision aids in that they prompt providers to consider guideline-based advice when a patient record, and ideally the patient, is in front of the provider. As such, they have the potential to improve quality of care in that they augment the limited memory resource of a time-pressured, frequently interrupted clinician who provides intermittent care to multiple patients."

Patterson, Emily, et al.; *Journal of the American Medical Informatics Association* Volume 11 Number 1 Jan / Feb 2004

Clinical Practice Guidelines

The Veterans Health Administration (VHA), in collaboration with the Department of Defense (DoD) and other leading professional organizations, has been developing clinical practice guidelines since the early 1990s. Guidelines for the Rehabilitation of Stroke and Amputation and the Care Guide for Ischemic Heart Disease were among the first distributed throughout VHA in 1996 and 1997. Since that time, numerous other guidelines, including guidelines on Diabetes Mellitus, COPD, Major Depressive Disorder, Psychoses, Tobacco Use Cessation, Hypertension, have been developed and distributed for implementation throughout the system.

VHA defines clinical practice guidelines as recommendations for the performance or exclusion of specific procedures or services for specific disease entities. These recommendations are derived through a rigorous methodological approach that includes a systematic review of the evidence to outline recommended practice. Clinical guidelines are seen by many as a potential solution to inefficiency and inappropriate variation in care.

However, it is acknowledged that the use of guidelines must always be applied in the context of a provider's clinical judgment for the care of a particular patient. For that reason, the guidelines may be viewed as educational tools analogous to textbooks and journals, but in a more user-friendly format.

Benefits of Clinical Reminders

Clinical Practice Guidelines

Purpose of Guidelines

- Assure that the appropriate amount of care is provided (addressing both under & over-utilization)
- Reduce errors and promote patient safety
- Ensure predictable and consistent quality
- Promote learning and research
- Facilitate patient and family education

National Clinical Practice Guidelines Council (CPGC)

Veterans Health Administration (VHA) Directive 2002-007 established the National Clinical Practice Guideline Council (NCPGC) to coordinate the adoption, implementation, and evaluation of clinical practice guidelines throughout the system.

The Council functions to:

- Prioritize clinical areas for which guidelines need to be developed or adapted/adopted
- Oversee and participate in guideline development and/or adaptation
- Assure maintenance and timely revision of existing guidelines
- Collaborate with DOD regarding the use of guideline development to improve the quality of care and health management across VHA and the Military Health System
- Facilitate implementation of guidelines by coordinating dissemination, consulting on studies, promoting education, and identifying and eliminating barriers to guideline implementation

Benefits of Clinical Reminders

Clinical Reminders, Performance Measures, and Clinical Practice Guidelines

Each Veterans Integrated Service Networks (VISN) must comply with performance measures that address Prevention Index/Chronic Disease Index (PI/CDI), as well as with the Health Promotion And Disease Prevention Program Handbook 1120.2, which states that each VHA facility shall have a program to educate veterans with respect to health promotion and disease prevention and to provide veterans with preventive medical care that includes screening and other clinical services.

You can retrieve a copy of the handbook from the VA publications page.
http://vaww.va.gov/publ/direc/health/handbook/1120-2hk.doc

The Clinical Reminders package offers tools to help clinicians comply with these performance measures and guidelines on a patient-by-patient basis. The use of these tools leads to improved patient care.

Providers can work with their local Clinical Application Coordinators to set up customized reminders based on local and national guidelines for patient education, immunizations, skin tests, measurements, exams, laboratory tests, mental health tests, radiology procedures, and other procedures.

For further information, see the PowerPoint presentation, "Implementing a Clinical Guideline Using Clinical Reminders," available on the national Clinical Reminders web page
http://vista.med.va.gov/reminders/

The Office of Quality and Performance oversees the VA's perfromance measure plan. Each year the Performance Measurement Workgroup (PMWG), recommends the annual Network Performance Plan to the Under Secretary for Health. The Plan is formally signed as the Network Director's annual performance appraisal. The specific details of the plan are published annually on the OQP website.
http://vaww.oqp.med.va.gov/default.htm

Benefits of Clinical Reminders

Functionality in Version 2

Clinical Reminders V. 2.0 supports Phase II of the Ischemic Heart Disease (IHD) and Mental Health QUERI projects. It adds four *new* IHD reminder definitions, two *modified* reminder definitions, modified reminder dialogs, reminder taxonomies, reminder terms, and health factors.

It also redistributes three Mental Health (MH) reminder definitions, along with the reminder dialogs, reminder taxonomies, and reminder terms, and health factors to support Phase II of the MH project.

Also included in version 2:

- Functionality for VA-GEC Referral (Geriatric Extended Care)
- New Health Summary Reminders components and types to support MyHealtheVet
- New Reminders and dialogs to support the CPRS: Integration with Women's Health project
- Corrections for problems reported in National Online Information Sharing (NOIS)
- Improved reminder evaluation functionality

Most of the changes in Version 2.0 of Clinical Reminders are technical and behind-the-scenes, affecting reminder definition and set-up. For further information, see your Clinical Applications Coordinator (CAC) or the Clinical Reminders website: http://vista.med.va/gov/reminders/

Set-up of Clinical Reminders

Clinician Role in Setting up Reminders

Clinicians play a role in the setup of reminders in the following ways:

1. Defining clinical reminder definitions and using them within Health Summaries, the CPRS GUI, and on encounter forms. Clinicians will be asked to assist Clinical Application Coordinators in selecting which reminders to implement and in defining the clinical aspects of the Clinical Reminder definitions, including:
   - Defining Baseline Age Range Set(s)
     - Reminder Frequency
     - Minimum and Maximum Age
   - Defining findings that identify whether the reminder applies to the patient, findings that resolve (satisfy) the reminder, and findings that provide additional clinical information-only from the following finding types:
     - Health Factors, Immunizations, Skin Tests, Education Topics, Exams
     - Taxonomies (ICD Diagnosis, ICD0 Operation/Procedure, CPT Procedure ranges)
     - Lab Tests and Radiology Procedures
     - Local Drugs, Generic Drugs and Drug Classes
     - Vital Signs
     - Orders to place
     - Computed Findings to handle miscellaneous findings (such as veteran status, BMI, race and ethnicity).

2. Defining and using dialogs to resolve reminders. Within CPRS GUI, the clinician uses a point-and-click interface (dialog) for each reminder chosen to process. As you select check-boxed text indicating actions you performed at a given encounter, text is accumulated to add to the note in progress. When you have finished processing the reminders, encounter information is entered in PCE, orders are placed, vital signs are updated, and mental health tests are scored and stored in the Mental Health package, according to your selections.

   You can help your clinical coordinators define a list of possible actions related to the reminder, to create the appropriate dialog check-boxes for each reminder.
3. The clinician plays a major role by advising when encounter forms are a clinically appropriate method of entry of health factors, education topics, immunizations and skin tests into Patient Care Encounter (PCE) to satisfy the clinical reminders. In many clinical settings reminder dialogs offer the advantage of not only passing the information to PCE but also of clinical documentation in progress note text where it is easily available for other users.

II. Using Clinical Reminders

Chapter 1: Clinical Reminders and CPRS Overview

Using Clinical Reminders in CPRS

Clinician reminders display in CPRS in four places:

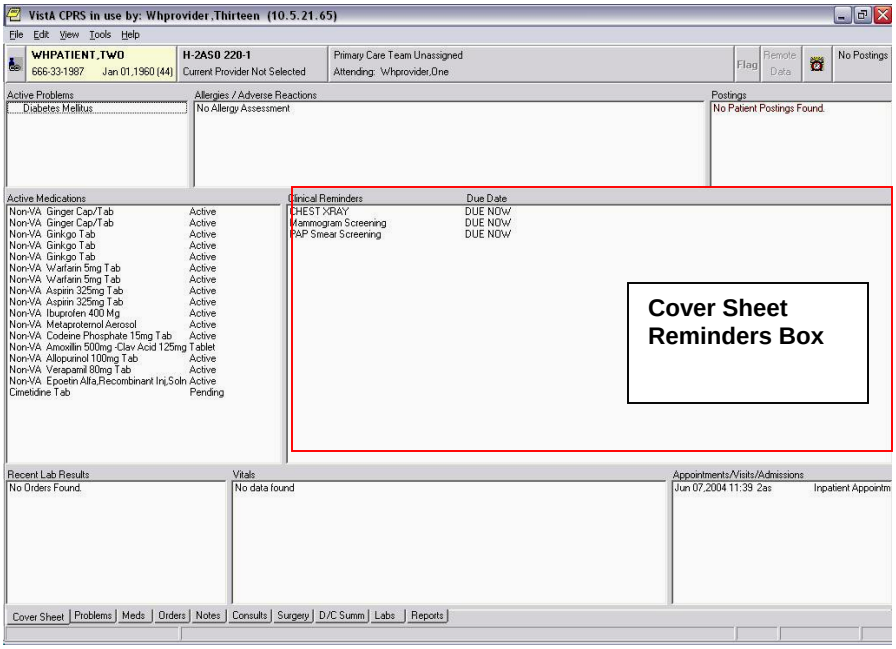
- Cover Sheet
- Clock button (upper right-hand corner of each tab in CPRS)
- Notes tab
- Reports tab (Health Summaries)

The cover sheet display of reminders can be customized for Site, System, Location, or User.

Cover Sheet

Clinical reminders are displayed on the cover sheet of CPRS. When you left-click on a reminder, details are presented in a pop-up window. By right-clicking on a reminder on the cover sheet, you can access the reminder definition and reference information.

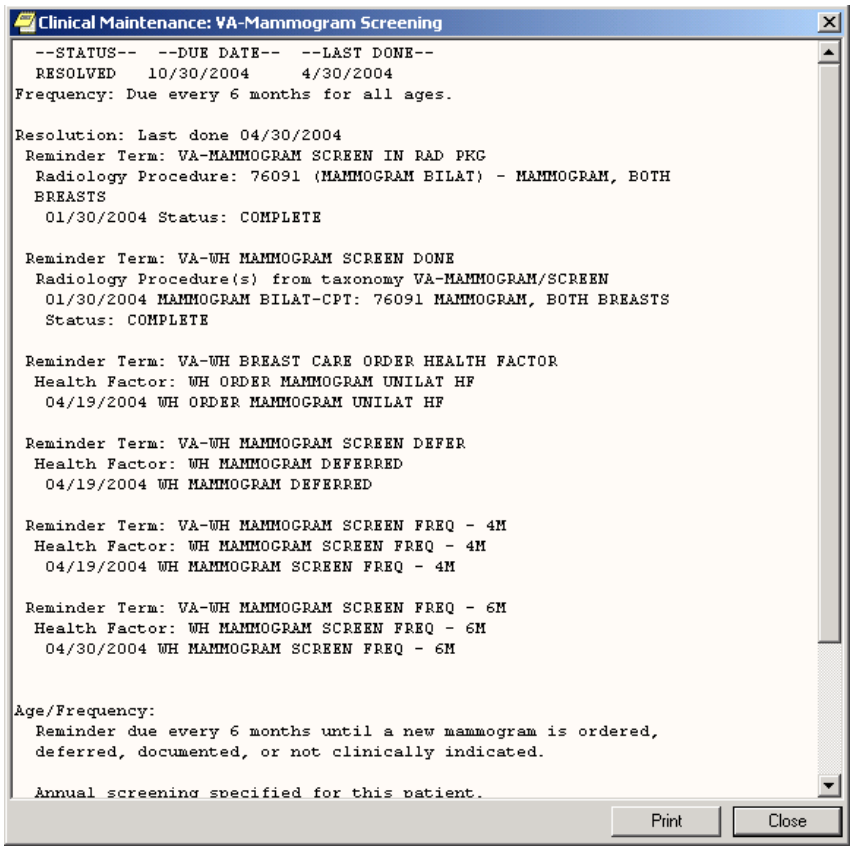
More details about what's available from the Cover Sheet are provided in the following pages.



Chapter 1: CPRS and Reminders Overview

The Clinical Maintenance display seen in CPRS GUI has been expanded to include more details, such as relevant Reminder Terms and Health Factors.

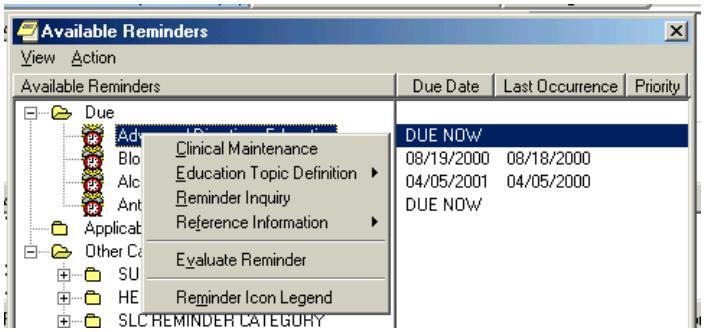
If you left-click on a particular reminder you will see the Clinical Maintenance output, which gives you the details of the reminder evaluation. It tells you things such as why the reminder is due for your patient and what the reminder requires.



II. Using Clinical Reminders

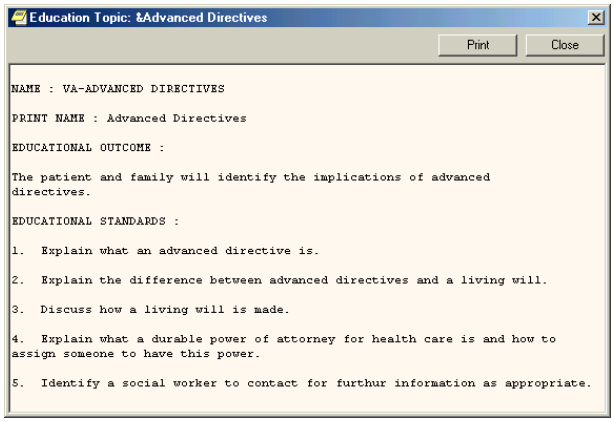
Chapter 1: Clinical Reminders and CPRS Overview

If you right-click on a reminder, you will bring up a popup menu that looks like this:



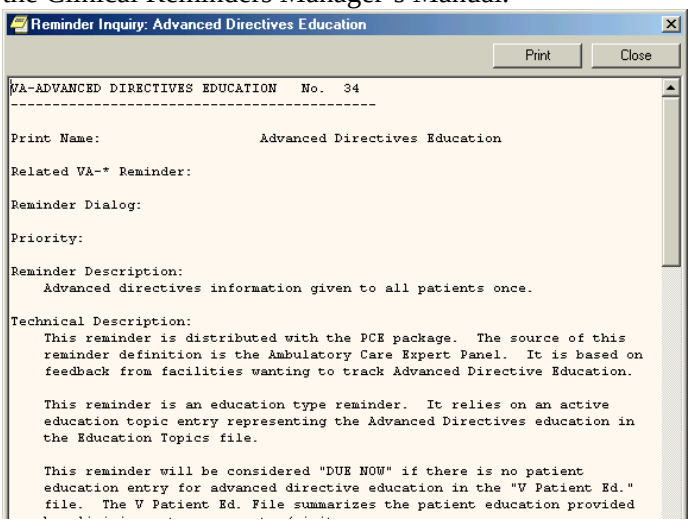
Clicking on Clinical Maintenance will give you the same Clinical Maintenance output you get by left-clicking.

If the reminder contains education topics, Education Topic Definition will be selectable and clicking on it will display the education topic definitions.



Chapter 1: CPRS and Reminders Overview

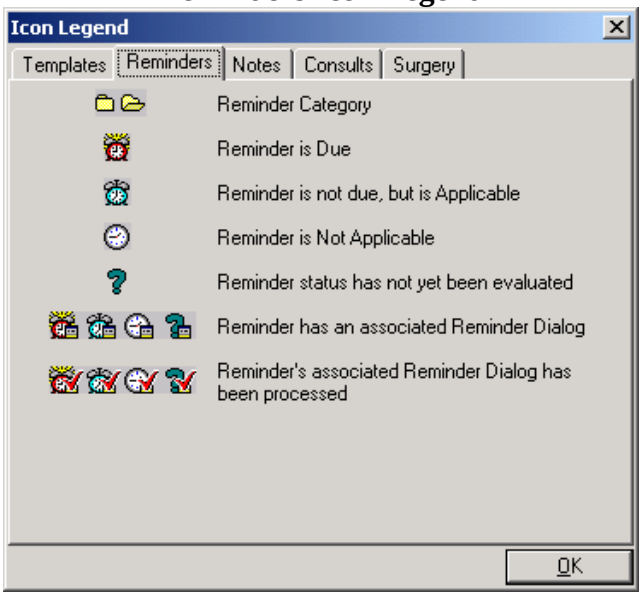
Clicking on reminder inquiry will produce a display of the reminder definition. For detailed information on how reminders are defined, see the Clinical Reminders Manager's Manual.



If you click on Reference Information, you will get a list of web sites that have information related to the clinical reminder. Clicking on one of them will open your web browser at that site.

Clicking on Reminder Icon Legend will bring up a display that shows what the various reminder icons mean.

Reminders Icon Legend

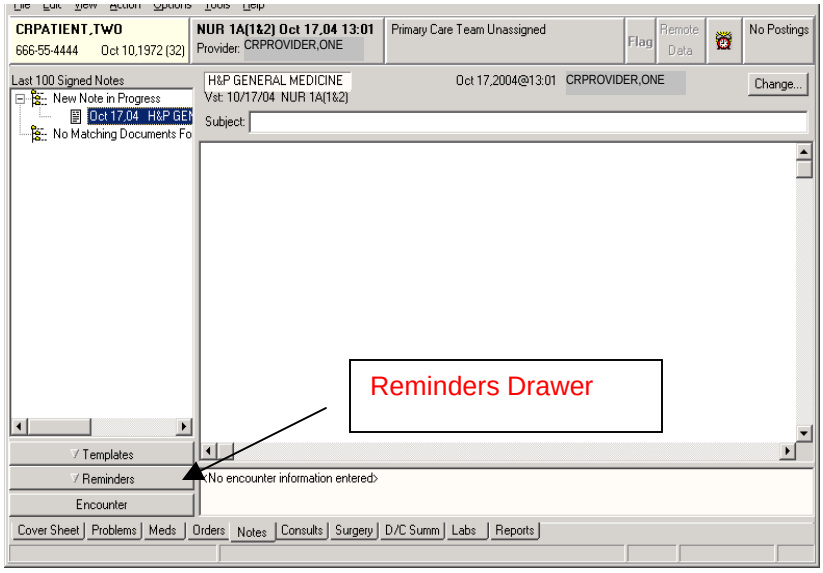


Chapter 1: CPRS and Reminders Overview

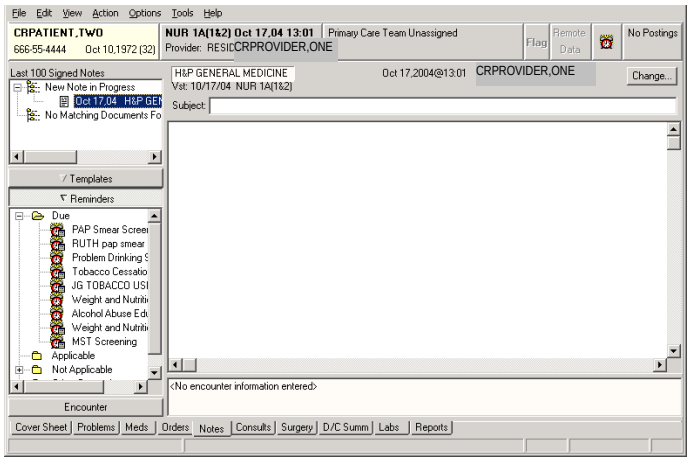
TIP:

You or your site can determine the folder view, and whether the folders are open or closed when you first open the reminders drawer.

The next place you are likely to encounter Clinical Reminders is on the Notes tab. When you go to the Notes tab and open a new note, a Reminders drawer appears.



When you click on the Reminders drawer a reminder tree is displayed.



The contents of the tree can be determined by the user. Details of how this is done are found in Appendix C on page 72. Reminders that have an associated dialog have a special icon, see the above display of reminder icons. If you click on one of these reminders, a dialog box appears, which lists possible actions or activities that may satisfy this reminder. Using a dialog to resolve a clinical reminder is discussed in Chapter 2.

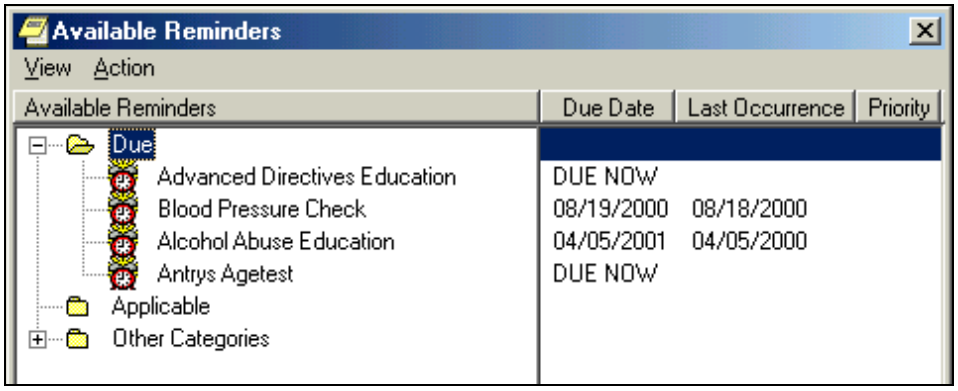
Chapter 1: CPRS and Reminders Overview

Users have the ability to edit their own list of cover sheet reminders. (Before you do this we recommend that you check with your Reminder Manager to find out which reminders are recommended for your work area.) Click on the Tools menu then click on Options.

Clicking on Clinical Reminders will open one of two cover sheet editing forms. The one you see depends on the setting of a parameter called ORQQPX NEW REMINDER PARAMS, but this is not something you will need to worry about. CPRS will automatically determine which form is appropriate for you to use. See Appendix C, page 72 for instructions on how to Edit Cover Sheet Reminders.

Clock Button
Another place you can interact with Clinical Reminders is by clicking on the reminders button (it looks like an alarm clock) in the upper right hand corner of the CPRS GUI.

This brings up the Available Reminders form which provides the same tree view you saw in the reminders drawer.

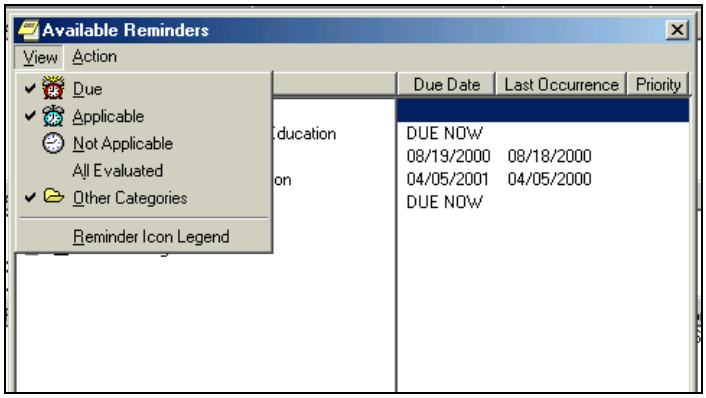


Chapter 1: CPRS and Reminders Overview

Available Reminders form
This form has two menus: View and Action.

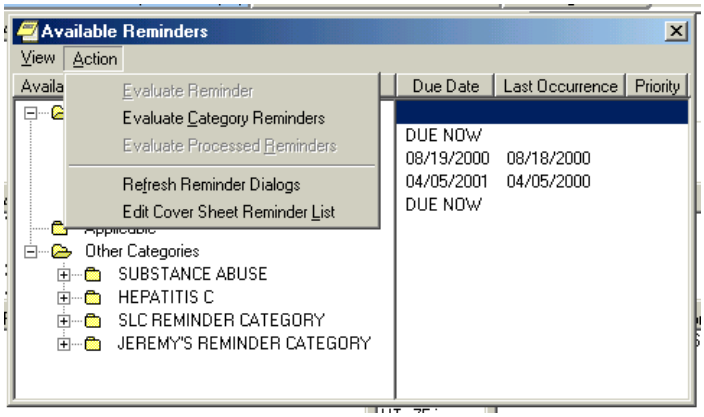
View Menu
The View menu lets you determine which categories of reminders will be displayed in the tree view. Those with a checkmark to the left of this will be displayed. You can toggle the checkmark on or off by left clicking on the icon. Note: as soon as you click on an icon the View menu will disappear and the tree will be updated to match your current selection. To make another change, left-click on View.

As was mentioned earlier, the tree you see here is identical to the one you see in the Reminders drawer, so whatever change you make here affects the tree you see in the Reminders drawer.



Of primary interest to the clinician are the options on the Action menu that let you evaluate reminders.

Action Menu



Chapter 1: CPRS and Reminders Overview

Available Reminders form

Action Menu
Evaluate Reminders
You can evaluate an individual reminder, all the reminders in a category, or a processed reminder. A processed reminder is one whose dialog has been processed. Which of these three options is selectable will depend on what has been selected on the reminders tree. If it is an individual reminder then Evaluate Reminder will be selectable, if it is a category then Evaluate Category Reminders will be selectable, and if it is a processed reminder then Evaluate Processed Reminder will be selectable.

The other two options are for Reminder Managers.

CPRS Reports Tab
Health Summaries containing Clinical Reminders can be viewed from the Reports tab in CPRS. See the Health Summary section later in this guide for more information.

The Ad hoc health summary can also be used to display selected clinical reminders using either an abbreviated display or the full clinical maintenance display. (See Chapter 6: Health Summaries and Clinical Reminders)

Chapter 2: Resolving Clinical Reminders

TIP:

Your site can determine the folder view – which reminders and categories/folders appear in the reminders drawer.

Summary of Steps to Process Reminders

These are the basic steps for processing reminders from the Notes tab in CPRS. These steps are described in more detail in Chapter 3.

1. **Start a new progress note.** To process a reminder, start a new progress note. When you begin a new progress note, the reminders drawer appears.

2. **Open the reminders drawer.** When you click on the reminders drawer, you see several folders containing reminders for this patient. Possible folders include Due, Applicable, Not Applicable, All Evaluated, and Other Categories. These folders may contain a hierarchy of folders and reminders within folders. The view of folders is customizable by you (see Appendix C, page 72). The folders and subfolders in the Reminders Drawer are sometimes called the "tree view."

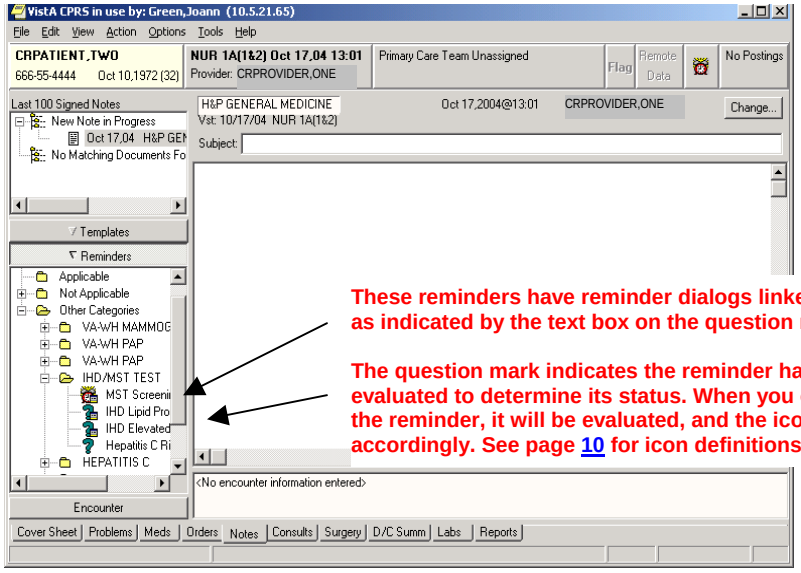
3. **Choose a reminder.** Open a folder (if necessary) and click a reminder that you wish to process. At this point, you may be asked to provide the primary encounter provider, so that any PCE data entered from reminder dialog processing can be saved.

Chapter 2: Resolving Clinical Reminders

Summary of Steps to Process Reminders

4. **(cont'd)** If the reminder has an associated reminder dialog, a small dialog icon is shown in the bottom-right corner of the clock icon. If you click on one of these reminders, a dialog box appears, which lists possible actions or activities that may satisfy this reminder. If this is a National reminder, the dialog was created by national developers and/or members of the Office of Quality and Performance. Otherwise, the contents of this dialog were created at your site by your Clinical Application Coordinator (CAC) or a Clinical Reminders Manager. Clinicians should be involved with defining these dialogs.

   If no dialog icon is displayed on a reminder, it means that your site hasn't created and/or linked a dialog to the reminder. Your CAC can provide information about this. Definitions of the reminders icons are available on the Action menu of the Available Reminders window (see page 13) .



Chapter 2: Resolving Clinical Reminders, cont'd

Summary of Steps to Process Reminders, cont'd

5. **Complete the dialog box.** The dialog box lists possible actions or interventions that may be taken to satisfy this reminder. As you make selections from the dialog box, you can see the text of the progress note in the bottom part of the screen (below the Clear, Back, and Next buttons). Below the progress note text area is the encounter information including orders and PCE, Mental Health, and Vital Sign data. The bold text in these areas applies to the specific reminder you are processing. You can process multiple reminders.

6. **Expanded dialog boxes.** Clicking a checkbox may bring up additional choices: an area for comments, a diagnosis to choose, or other information that may satisfy the reminder.

   Dialog with orders. Reminder dialogs can include orders. If quick orders are included in the dialog, these are placed as soon as the reminder processing is finished and the orders are signed. If the order requires more information before releasing the order, an order dialog will appear after you click Finish, allowing you to complete the order.

   Mental health tests. Reminder dialogs can include a pre-defined set of mental health tests. The reminder definition can include any mental health test, but the reminder dialog is limited in the GUI resolution process to allow clinicians to enter results for the following tests: AIMS, AUDC, AUDIT, BDI, CAGE, DOM80, DOMG, MISS, and ZUNG. Progress note text can be generated based on the mental health score.

7. **Finish processing the reminder and complete your note.** Click on the Finish button when you have checked all the appropriate checkboxes for each reminder you wish to process. You then go back to the Note window, where you can review and edit the reminder dialog progress note text added, to have a completed progress note for the encounter.

8. **(Optional) Evaluate processed reminders.** You can use the Action menu to select the Evaluate Processed Reminders menu item from the Reminders Available window, to ensure that the reminders are satisfied. This action will evaluate the reminders that you processed while you wait, and update the Reminders Available window and reminders drawer lists to reflect the new statuses.

TIP:

☞ Use the Next or Back buttons to take you to the dialog for the next or previous reminder due in the reminders drawer.

Chapter 3: Resolving IHD Reminders

Overview

IHD Reminder Definitions
The following IHD reminder definitions are distributed with Clinical Reminders Version 2.0:

VA-IHD LIPID PROFILE
This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code for IHD on or after 10/01/99) who have not had a serum lipid panel within the last year. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

VA-IHD ELEVATED LDL
This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code on or after 10/01/99) who have had a serum lipid panel within the last year, where the most recent LDL lab test (or documented outside LDL) is greater than or equal to 120 mg/dl. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

VA-*IHD LIPID PROFILE REPORTING
This national IHD Lipid Profile Reporting reminder is used monthly to roll up LDL compliance totals for IHD patients. This reminder identifies patients with known IHD (i.e., a documented ICD-9 code for IHD) who have not had a serum lipid panel/LDL (calculated or direct lab package LDL) or documented outside LDL within the last two years. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

VA-*IHD ELEVATED LDL REPORTING
This national IHD Elevated LDL Reporting reminder is used monthly to roll up compliance totals for management of IHD patients whose most recent LDL is greater than or equal to 120mg/dl. This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code) who have had a serum lipid panel within the last two years, where the most recent LDL lab test (or documented outside LDL) is greater than or equal to 120 mg/dl. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient. These compliance reminders are not for use in CPRS, so there are no related reminder dialogs.

Chapter 3: Resolving IHD Reminders

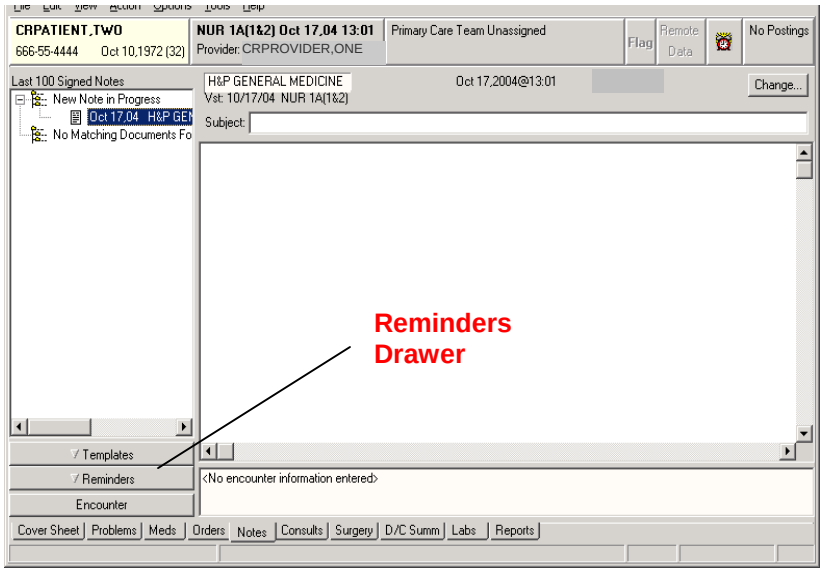
TIP:

You or your site can modify the contents of the "Other Categories" folder, through the option Add/Edit Reminder Categories on the CPRS Configuration Menu.

Steps to Process VA-IHD Lipid Profile

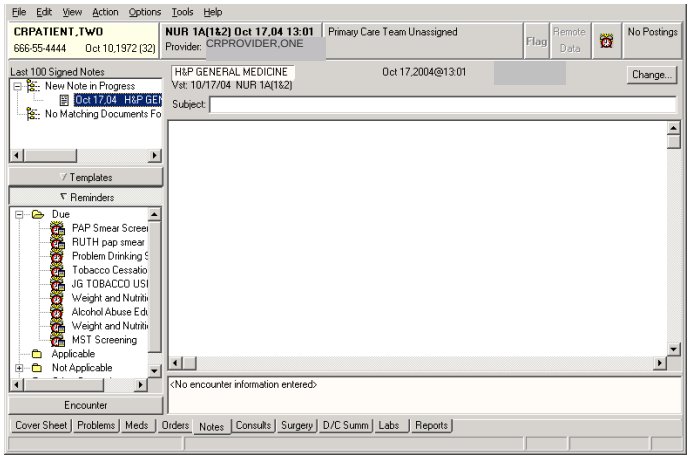
1. Start a new progress note.

When you begin a new progress note, the reminders "drawer" appears below the default list of notes. You will be prompted to enter Progress Note properties (Title, date, etc.) before you begin processing reminders.



2. Open the reminders drawer

Click on the reminders drawer (button) to see reminders. Due, Applicable, Not Applicable, All Evaluated, or Other Categories folders may be displayed, enclosing those kinds of reminders. .



Chapter 3: Resolving IHD Clinical Reminders

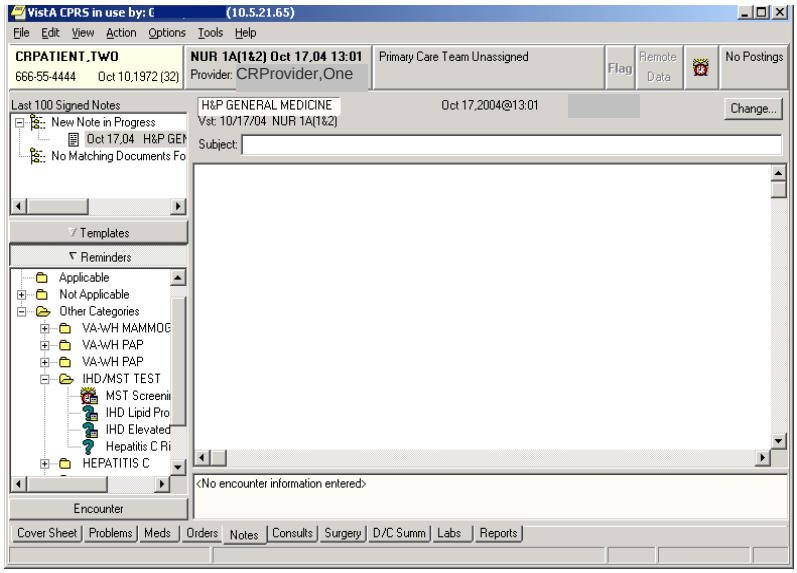
TIP:

To process a reminder, a "reminder dialog" must be defined and associated (linked) with the reminder. This is done by your Clinical Reminders Manager or coordinator (usually with clinician assistance). If a reminder dialog is available for a reminder, an icon representing a dialog is on the corner of the reminder icon.

Steps to Process VA-IHD Lipid Profile, cont'd

3. Locate the IHD Lipid Profile reminder.

If necessary, open a folder (Due, Applicable, Other Categories, etc.) and click on the IHD Lipid Profile Reminder.



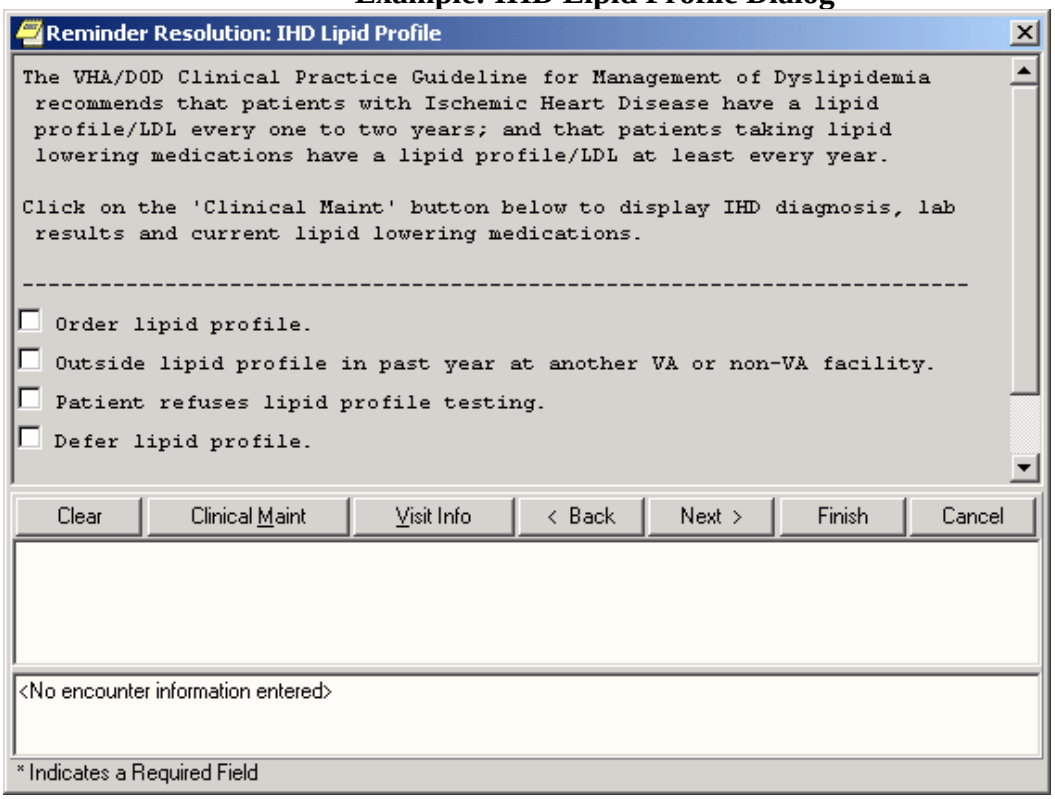
Chapter 3: Resolving IHD Clinical Reminders

Steps to Process VA-IHD Lipid Profile, cont'd

4. Complete the dialog box.

When you select the IHD Lipid Profile reminder to process, a dialog box appears, such as the one below. It shows the possible things that may satisfy the reminder.

Example: IHD Lipid Profile Dialog



Steps to Process VA-IHD Lipid Profile, cont'd

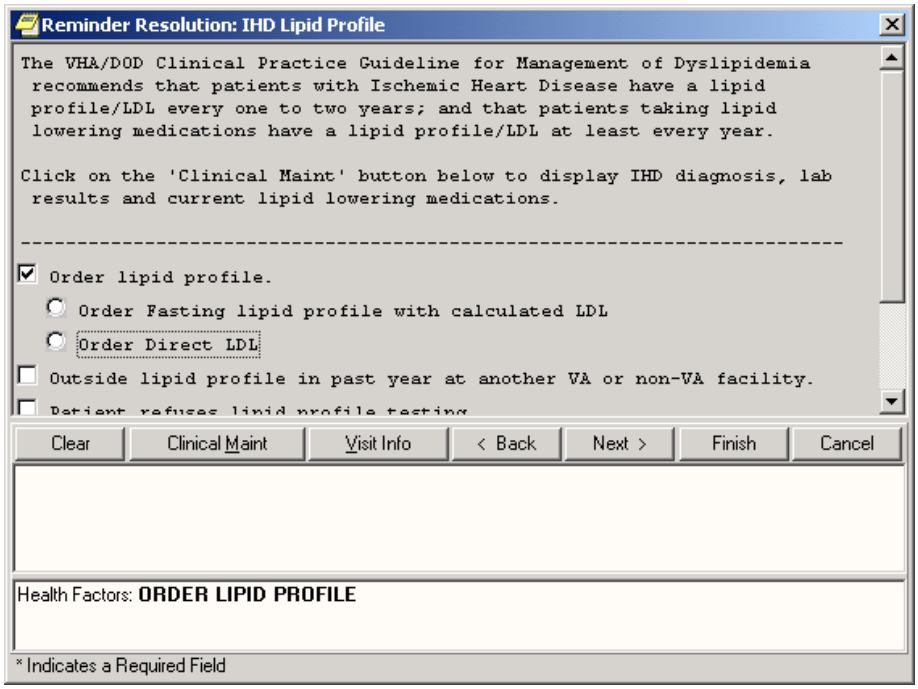
4. Complete the dialog box, cont'd.

If quick orders are included in the reminder dialog, these are activated as soon as the progress note is completed and the note and order are signed. If the order requires more information before completion, an order dialog will appear after you click Finish, allowing you to complete the order.

When you click a checkbox or item, the associated text that will be placed in the progress note is shown in the area below the buttons. Data that will update PCE, orders, Vital Signs, and Mental Health packages will be shown in the area below that.

See the example on the next page.

Example: Expanded Dialog when "Order Lipid Profile" Checked



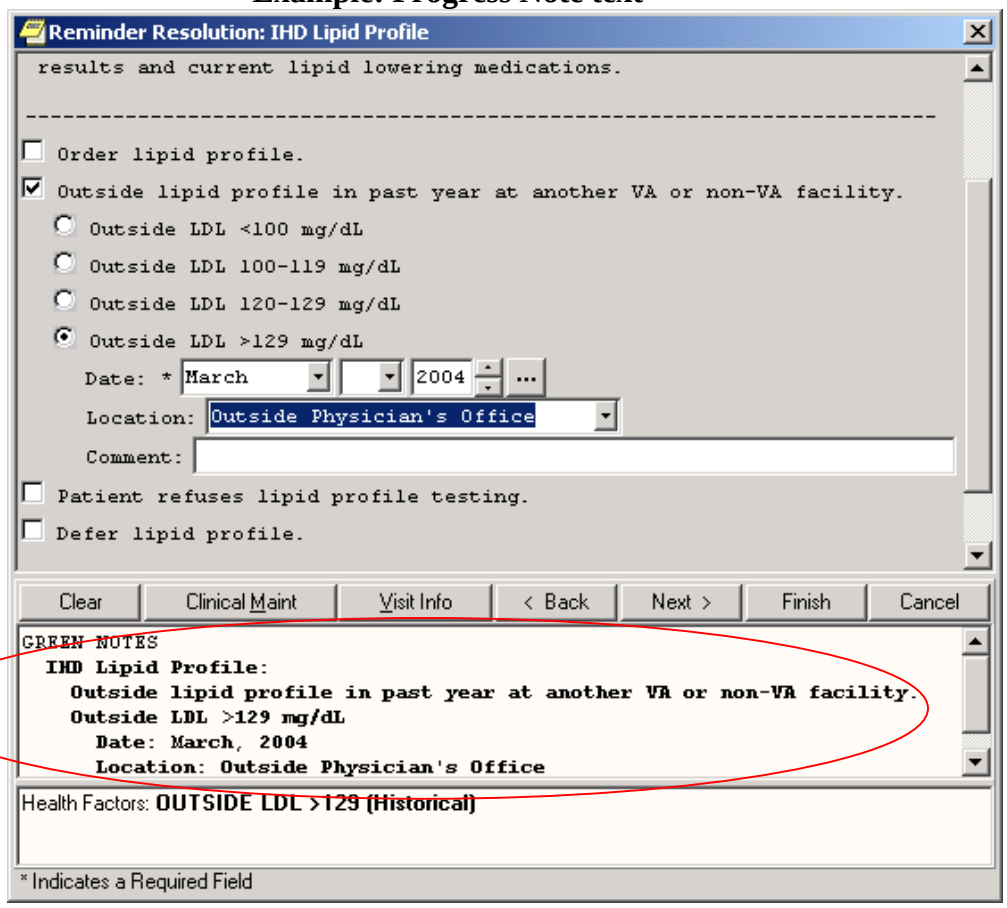
Chapter 3: Resolving IHD Clinical Reminders

Steps to Process VA-IHD Lipid Profile, cont'd

4. Complete the dialog box, cont'd.

When you click a checkbox or item, the associated text that will be placed in the progress note is shown in the area below the buttons. Data that will update PCE, orders, Vital Signs, and Mental Health packages is shown in the area below that.

Example: Progress Note text



Chapter 3: Resolving IHD Clinical Reminders

Steps to Process VA-IHD Lipid Profile, cont'd

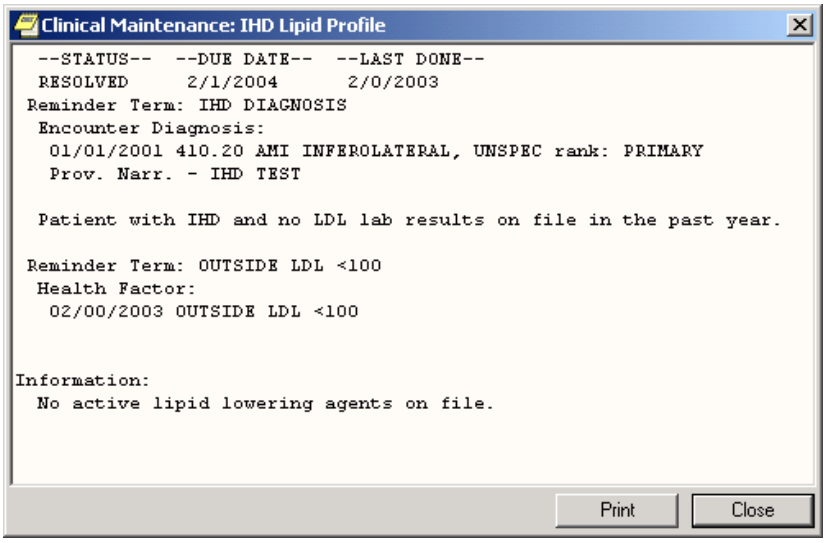
Next and Back processing
Use the Next button to process the next reminder that is due in the reminders drawer. Use the Back button to take you to the reminder processed previously to the one you are currently processing.

Clinical Maintenance review
While processing the reminder, you can review current Clinical Maintenance patient data related to the reminder by clicking on the Clinical Maint button at the bottom of the dialog box.

NOTE: Information in the Clinical Maintenance box has been expanded and enhanced in Version 2 of Clinical Reminders.

Clearing a single reminder
You will probably process several reminders for a single visit. If you have entered information on a reminder, but you need to start over on that reminder only, you can simply click Clear on the reminder from the reminders drawer, and then click the Clear button in the reminders dialog box. This removes all previous dialog selections from the reminder's dialog box and removes the related text and data from the Progress Note text box and the PCE data box for this reminder. You can now start processing again. NOTE: Clicking Clear will remove the information from only one reminder. Be careful that you are on the correct reminder before you click Clear.

Example: Clinical Maintenance window for IHD Lipid Profile



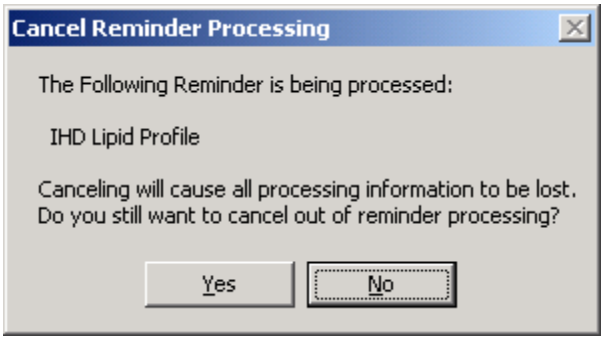
Chapter 3: Resolving IHD Clinical Reminders

Steps to Process VA-IHD Lipid Profile, cont'd

Canceling out of the Processing dialog
If you reach the Reminders Processing dialog by mistake or you wish to delete information that you have entered and start over, click Cancel.

NOTE: If you click Cancel, you will lose all of the information for reminders that you have entered.

Example: Warning box when Cancel button clicked



Chapter 3: Resolving IHD Clinical Reminders

Steps to Process VA-IHD Lipid Profile, cont'd

5. Finish processing the reminder

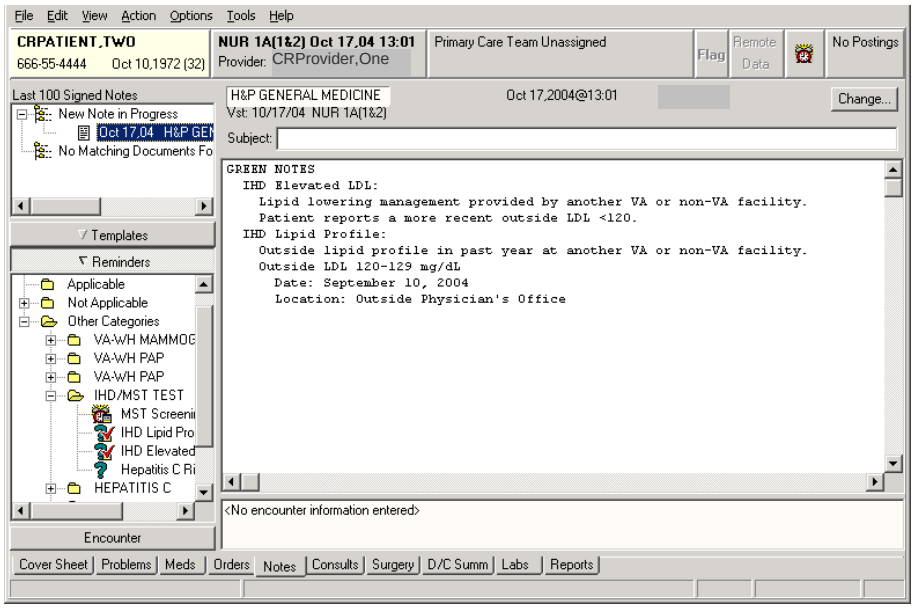
After you have entered all the information, you can finish processing the reminders. When you finish, the following things will happen:

- The predefined text is placed in the note you have begun writing.
- The encounter information is sent to PCE.
- If there are orders defined in the dialog, it will also create the orders. If the orders require input (if they are not predefined quick orders without prompts), the order dialogs will come up so that you can complete the orders. You will then have to sign any orders that are created.

To finish processing reminders, click Finish.

After you click Finish, you are returned to the Note screen, where you can see the text created by reminder processing. You can edit this, as necessary.

Example: Progress Note after reminder dialog completion



Chapter 3: Resolving IHD Clinical Reminders

Steps to Process VA-IHD Lipid Profile, cont'd

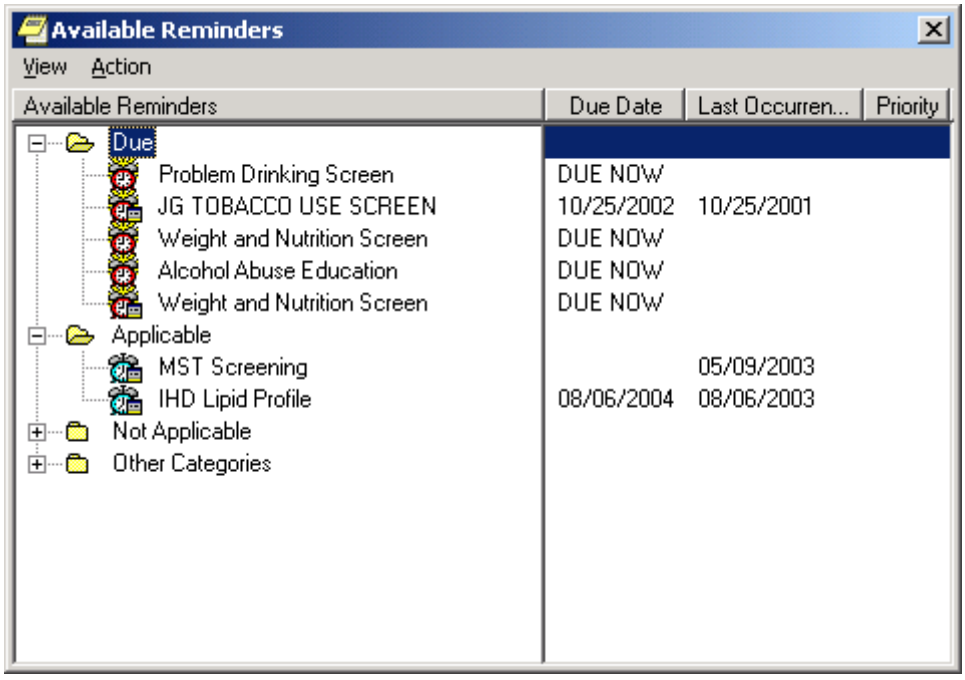
7. (Optional) Evaluate processed reminders

After you have processed a reminder, you can use this menu item in the Available Reminders window to see if your actions during the encounter satisfied the reminder. This action will evaluate the reminders that you processed while you wait, and update the Reminders Available window and Reminders drawer lists to reflect the new statuses.

NOTE: PCE data may take a few minutes to be correctly recorded. Please wait a few minutes after processing a reminder before evaluating it again to ensure that it was satisfied.

To evaluate processed reminders, go to the Available Reminders dialog by clicking on the Reminders button, choose Action, and then click on Evaluate Processed Reminders.

Example: Evaluate Processed Reminder



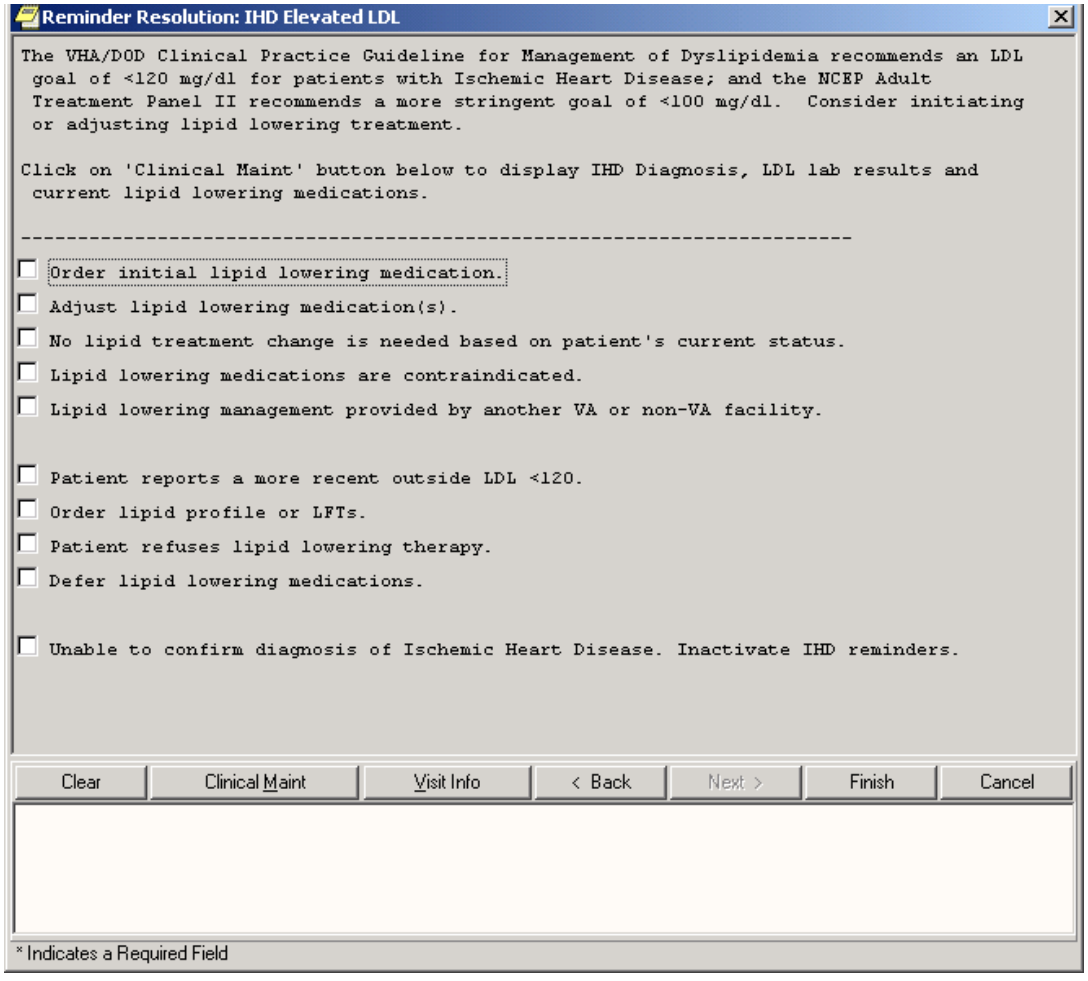
Chapter 3: Resolving IHD Clinical Reminders

VA-IHD ELEVATED LDL

This national reminder identifies patients with known IHD (i.e., a documented ICD-9 code on or after 10/01/99) who have had a serum lipid panel within the last year, where the most recent LDL lab test (or documented outside LDL) is greater than or equal to 120 mg/dl. If a more recent record of an UNCONFIRMED IHD DIAGNOSIS is found, the reminder will not be applicable to the patient.

Use the same steps to process this reminder as those described above.

Example: IHD Elevated LDL Dialog



Chapter 4: Processing Mental Health Reminders

Mental Health Reminders

The following Mental Health reminder definitions are re-distributed with Clinical Reminders Version 2.0:

VA-ANTIPSYCHOTIC MED SIDE EFF EVAL
The Abnormal Involuntary Movement Scale (AIMS) reminder has been designed to be due on all patients who are on any one of the antipsychotics (excluding ones like compazine). The taxonomy for Schizophrenia is included in the reminder, but will not be part of the cohort logic. By leaving the taxonomy in the reminder, data roll-up can use the Report Extracts functionality in version 2.0, either with or without information on patients with Schizophrenia.

VA-DEPRESSION SCREENING
Screening for Depression using a standard tool should be done on a yearly basis. The yearly screening is satisfied by entry of a health factor indicating positive or negative results for the 2 question MacArthur screening tool or by entry of negative or positive results in the MH package. The reminder is also resolved by entry of information indicating that the patient is already being treated/evaluated in a Mental Health clinic.

Patients are automatically excluded from the cohort if they have a recent diagnosis of depression (ICD code in the past 1 year) and have either a CPT code for psychotherapy in the past 3 months or are on antidepressant medication (current supply of medication in the past 3 months).

VA-POS DEPRESSION SCREEN FOLLOWUP
The reminder is applicable if the patient has positive depression screen in the past 1 year (DEPRESSION SCREEN POSITIVE). If a more recent negative depression screen is entered, then the reminder becomes not applicable (DEPRESSION SCREEN NEGATIVE).

Chapter 4: Processing Mental Health Reminders, cont'd

NOTE

Sites that use a different screening tool than the 2 question MacArthur screening tool will need to create local health factors to indicate a positive or negative result and will need to map those local health factors to the national terms: DEPRESSION SCREEN NEGATIVE, and DEPRESSION SCREEN

Mental Health Reminder Processing

Depression Screening

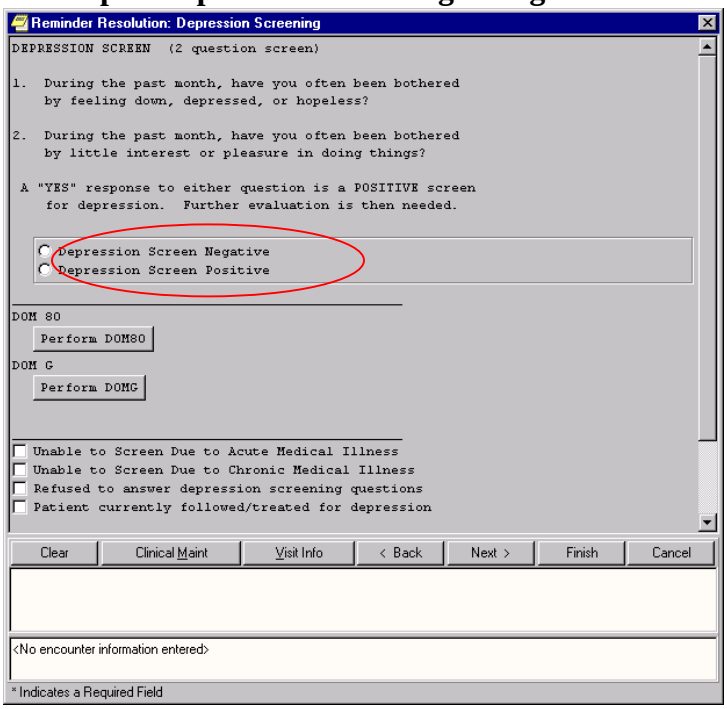
The yearly screening is satisfied by entry of a health factor indicating positive or negative results for the 2-question MacArthur screening tool or by entry of negative or positive results of any of the following in the MH package:

Negative	Positive
DOM80=0	DOM80=1
DOMG<4	DOMG>3
CRS<10	CRS>9
BDI<10	BDI>9
Zung<33	Zung>32

The reminder is also resolved by entry of information indicating that the patient is already being treated/evaluated in a Mental Health clinic.

Example: Depression Screening dialog initial window

2-question McArthur test

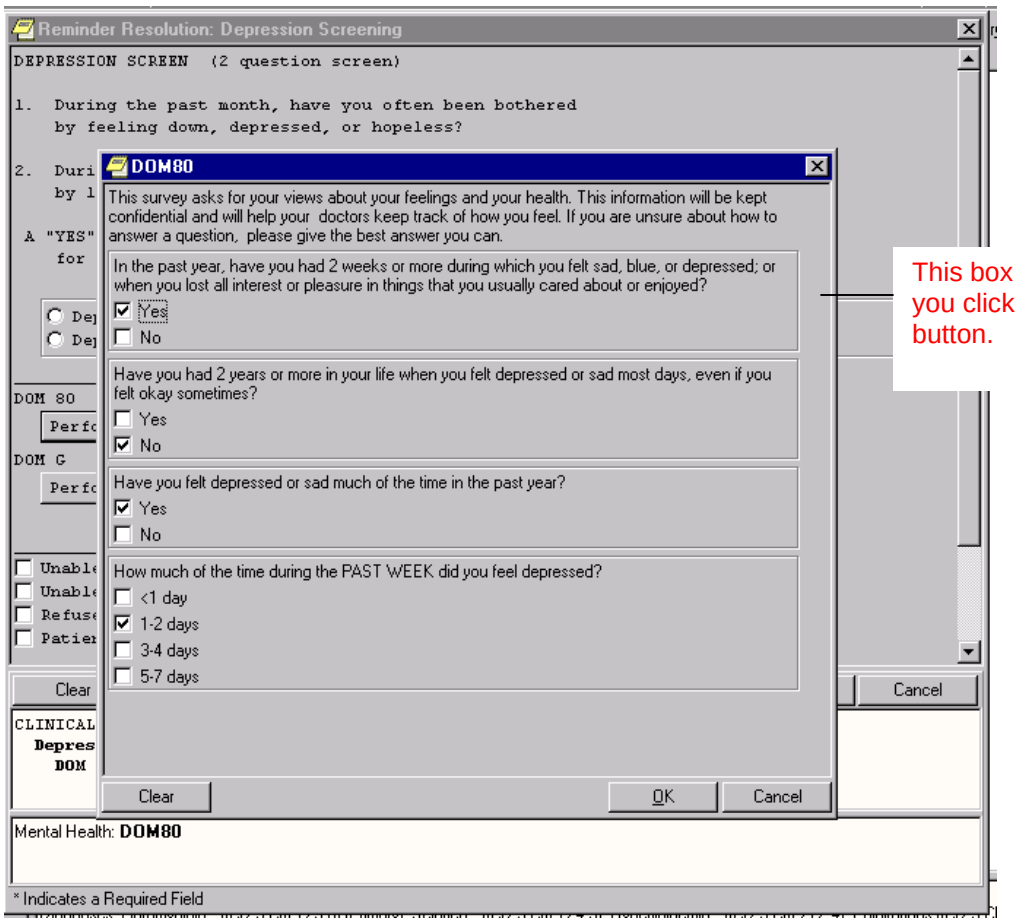


Chapter 4: Processing Mental Health Reminders, cont'd

Depression Screening (cont'd)

When you click on the DOM80 or DOMG button, a window pops up that lets you perform the test. The results of the test go in the patient's record – in the progress note and in the Mental Health package.

Example: DOM80 test



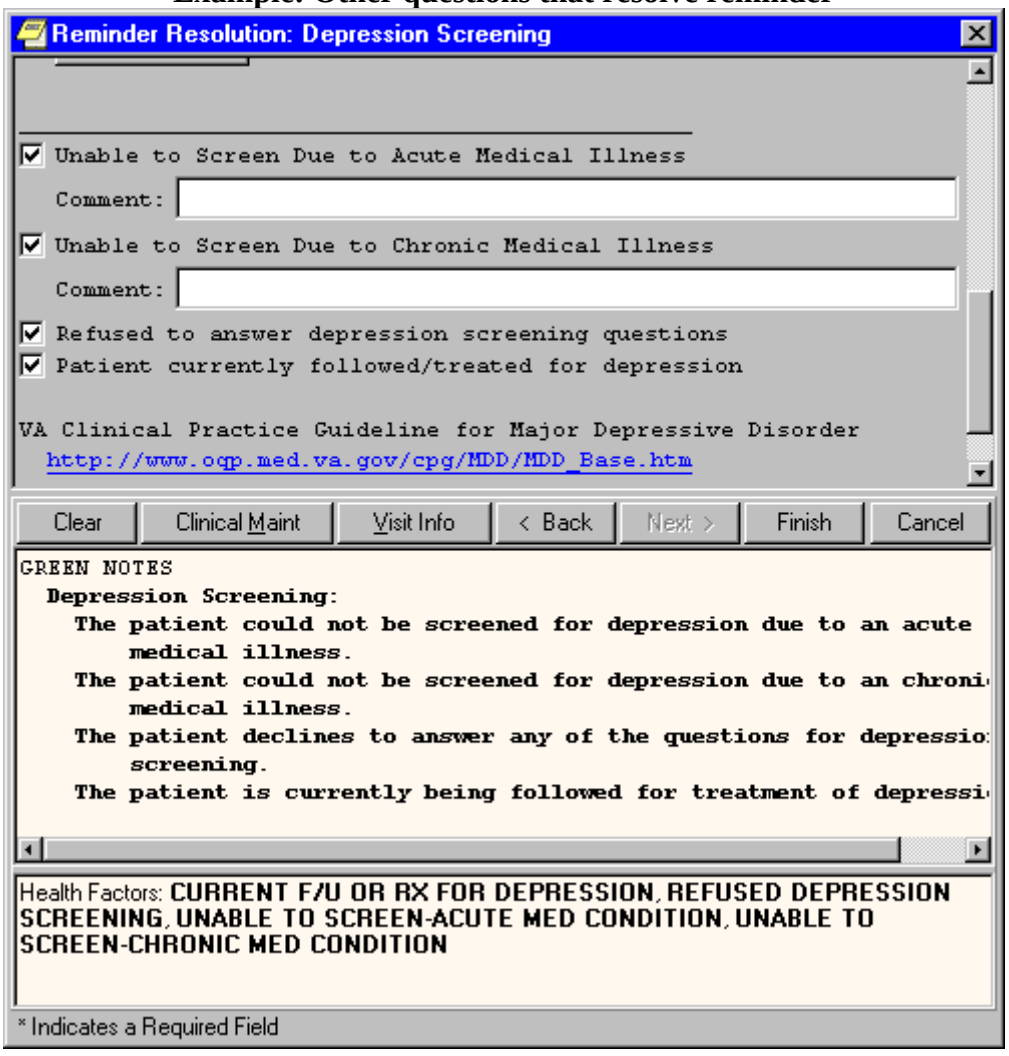
Chapter 4: Processing Mental Health Reminders, *cont'd*

Depression Screening (cont'd)

The reminder is also resolved by the following:

- Unable to screen due to acute or medical illness
- Patient refuses to answer depression screening questions
- Entry of information indicating that the patient is already being evaluated/treated in a Mental Health clinic

Example: Other questions that resolve reminder

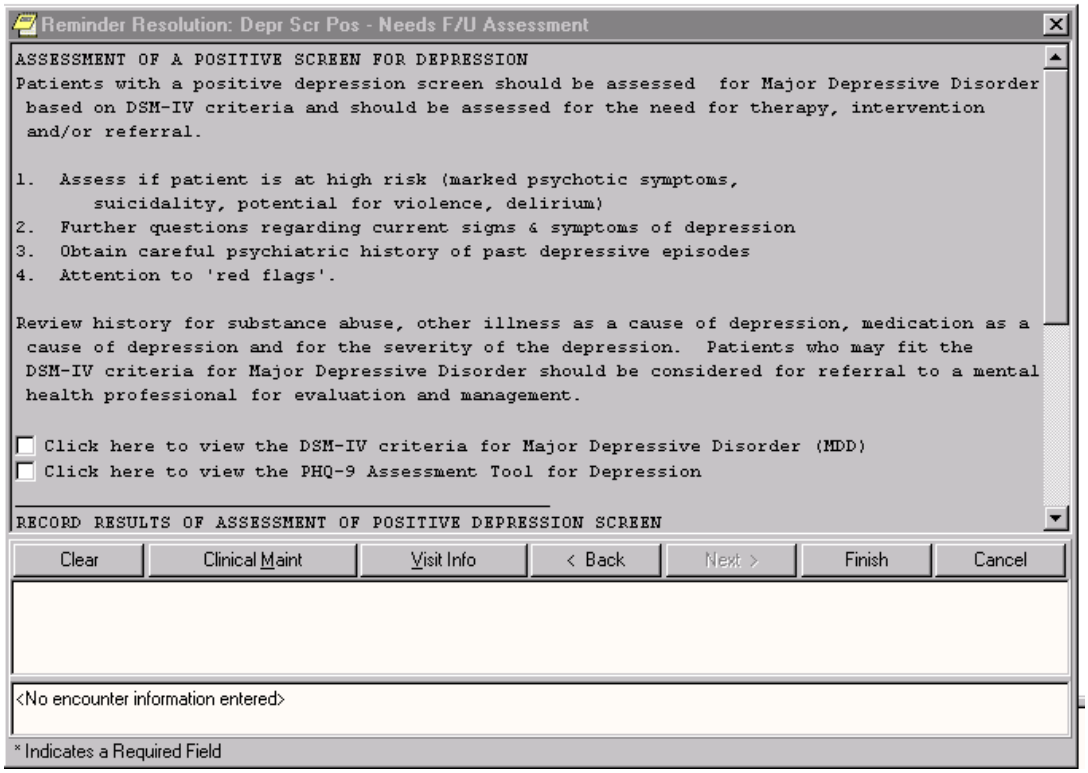


Chapter 4: Processing Mental Health Reminders, cont'd

Depression Screen Positive – Needs F/U Assessment

This reminder is applicable if the patient has positive depression screen in the past 1 year (DEPRESSION SCREEN POSITIVE). If a more recent negative depression screen is entered, then the reminder becomes not applicable (DEPRESSION SCREEN NEGATIVE).

Example: Depression Screen Positive



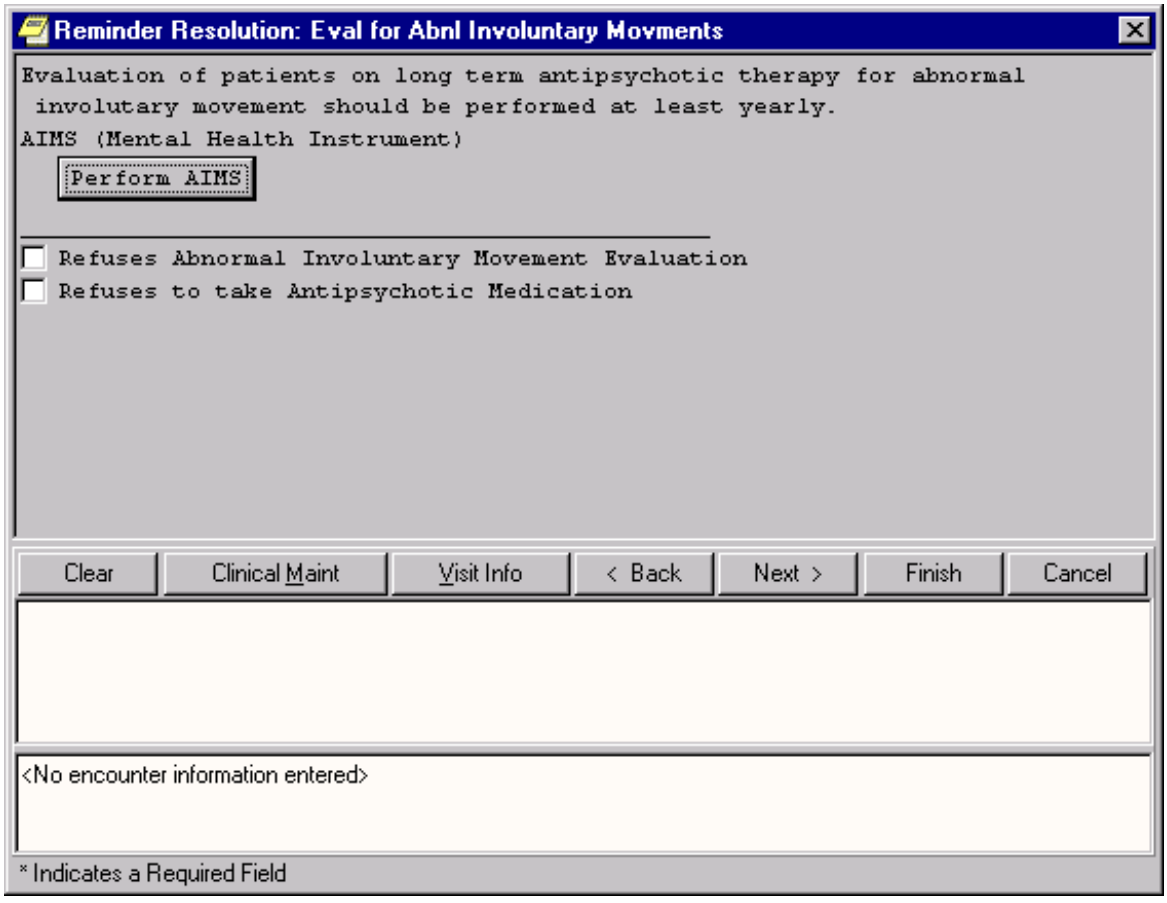
Chapter 4: Processing Mental Health Reminders, cont'd

Abnormal Involuntary Movement Scale, (AIMS) Dialog

This reminder dialog uses the AIMS Mental Health Instrument. If you click on the Perform AIMS button, the instrument pops up, so that you can answer the questions, which are scored and go into the Mental Health package and the Progress Note.

The reminder is also resolved by refusal to take the test or refusal to take antipsychotic medications.

Example: Eval for Abnl Involuntary Movements

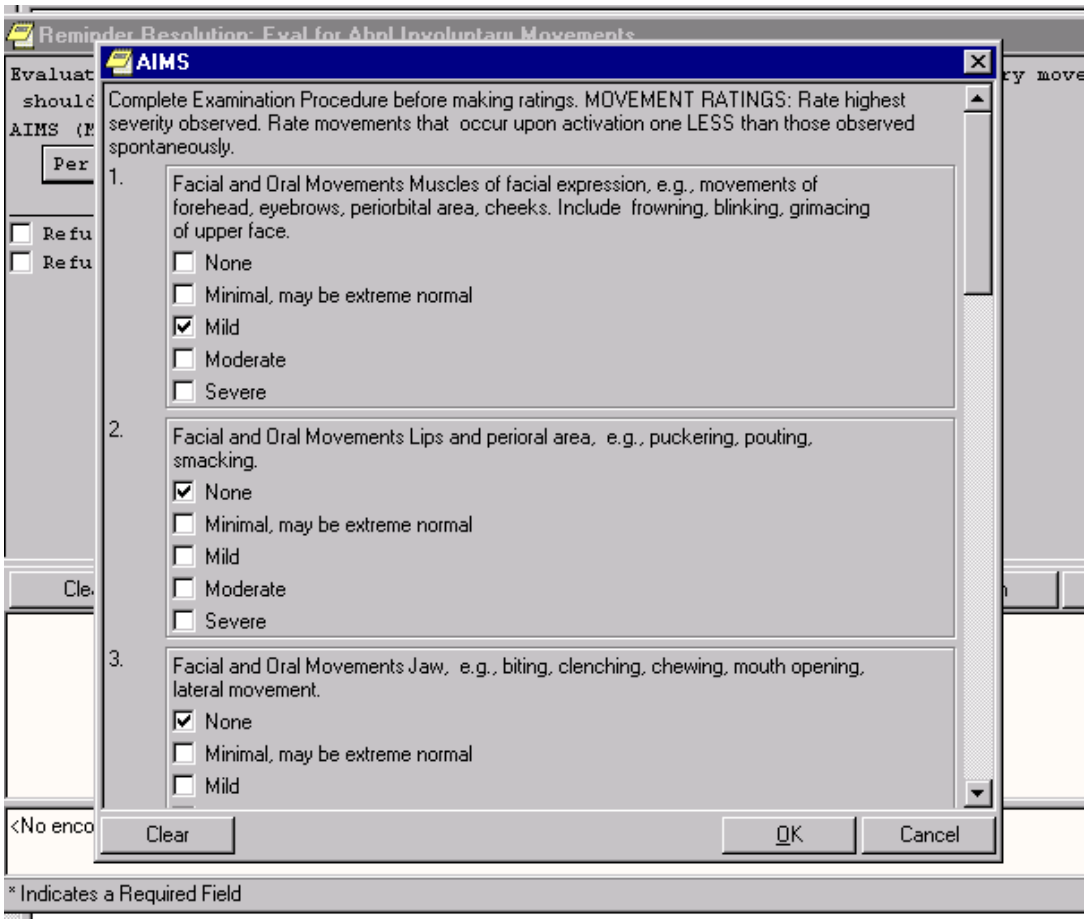


Chapter 4: Processing Mental Health Reminders, cont'd

AIMS Dialog

When you click on the Perform AIMS button, the screen below pops up, so that you can answer the questions, which are scored and go into the Mental Health package and the Progress Note.

Example: AIMS Mental Health Instrument



Chapter 5: Using Reminder Reports

TIP:

Reminder reports allow you to do large and small-scale comparisons of clinics, divisions, teams, and providers and can help in finding patients who have "slipped through the cracks."

Ever want to know how well your team is doing with immunizations or diabetes care or pain assessments?

Ever want to know who is coming this week who needs pneumococcal immunization, or who needs diabetic foot exam and education, or who has had a high pain score in the past and needs a pain assessment?

Would anyone at your site ever want to look at a group of patients for a research project – patients with a creatinine between 1.5 and 5 who do not have diabetes who are under the age of 80?

Chapter 5: Reminder Reports

Reports allow you to verify diagnoses, verify that appropriate treatment was given, identify patients requiring intervention, and validate effectiveness of care.

Reminder reports are very flexible. Reports can be run on:

1. Location(s)
    a. one or more inpatient hospital locations
        i. Current inpatients
        ii. Patients admitted during a date range
            1. Alphabetical
            2. Sorted by ward/bed
    b. one or more outpatient hospital locations
    c. all hospital locations
    d. stop code(s)
    e. clinic group(s)
2. OERR Team(s)
3. PCMM team(s),
4. PCMM provider(s)
5. Reminder patient list(s).

Reports can be combined or kept separate for one or more facility

Report results can display:

1. Summary results (numbers only)
2. Detailed results (patients names).
    a. Identifier
        i. Entire social security number
        ii. Last 4 numbers of social security number only
    b. Sort
        i. Alphabetically
        ii. Date of the next clinic visit.

Reports can be run on either on patients:

1. With Past visits or
2. With Future visits.

Clinicians should work with their site's clinical reminder coordinator or Clinical Application Coordinator to design and validate reports used at their site. Reporting can be resource-intensive and many sites have elected to centralize the access to run reports. However, limited report templates may be available to selected clinicians who work closely with clinical reminders or QM at their site.

Chapter 5: Using Reminder Reports

TIP:

The EPI extract finding list and total options are specific to the Hepatitis C Extract project. The extracted data is based on the following reminders: VA-HEP C RISK ASSESSMENT, VA-NATIONAL EPI LAB EXTRACT, and VA-NATIONAL EPI RX EXTRACT.

Reminder Reports, cont'd

Changes in Version 2

New reports on the Reminder Reports menu or changes to report functionality in Clinical Reminders V. 2.0:

- Extract Queri Totals [PXRM EXTRACT QUERI TOTALS] This option prints reminder and finding totals for extract summaries created by the automatic QUERI extracts.
- GEC Referral Report, [PXRM GEC REFERRAL REPORT] This option is used to generate GEC Reports. GEC (Geriatrics Extended Care) is used for referral of geriatric patients to receive further care.
- New type of report, Reminder Patient List, on Reminders Due option.
- Ability to show inpatient location on future appointments.

Chapter 5: Using Reminder Reports

TIP:

Reminders Due Report:

The summary report may be run for several reminders.

The detailed report may only be run for one reminder

Reminder Reports

Changes in Version 2

Version 2.0 of Reminders contains changes to the date range that can be used in searches in the Reminders Due reports. The changes include:

- Effective period and effective date are eliminated
  - Replaced with beginning date and ending date
- Any of the FileMan date formats are acceptable
  - May 14, 2003, T-1Y, T-2M, T-3D
- Beginning date default is beginning of data
- Ending date default is today

Benefits of Date Range Finding Searches

- The search for findings is done only in the specified date range.
- Retrospective reminder reports are now possible.

Reminders Due Report

For a selected reminder, the report lists any reminders that are currently due. Reports can be defined by the following criteria:

- Individual Patient
- Reminder Patient List (all patients on a patient list created through the Patient List options)
- Hospital Location (all patients with encounters)
- OE/RR Team (all patients in team)
- PCMM Provider (all practitioner patients)
- PCMM Team (all patients in team)

Summary report: displays totals of how many patients of those selected have reminders due.

Detailed report: displays patients (in alphabetical order) with reminders due. The report displays for each patient the date the reminder is due, the date the reminder was last done, and next appointment date. The detailed report can also list all future appointments, if specified. Detailed reports for Location or Provider may also be sorted by next appointment date.

Reports by Hospital Location, Provider, or Team print a separate report for each Hospital Location, Provider, or Team selected. Reports for all Hospital Locations are not separated by individual locations. The report by Hospital Location can report either current inpatients or admissions within a selected date range.

Chapter 5: Using Reminder Reports

Reminder Reports

Report templates
The selection criteria used for the Reminders Due reports may be saved into a report template file, with a user-specified identifier, as the report is being run.

When running the Reminder Due report, you may select from an existing template and run a new report using the parameters from the selected template. The prompts for date range and sort order are displayed, but all other parameters are taken from the previous report. If you select a print template, you may also edit the template and/or copy to a new template before running the report.

***Scenario**: How many patients are not receiving reminders who should be for Hepatitis C?*

A report can be prepared that compares "Applicable" reminders to those that have been defined as "Due." The difference may be a missed opportunity. This can be done by individual provider or for all providers in a location or medical center, as a quality assurance measure. The example below shows a summary report where the reminders selected are all related to Hepatitis C. This illustrates how you could use the summary report as part of a larger strategy for implementing and managing a Hepatitis C guideline using reminders.

Example Report

```
                        # Patients with Reminder
                            Applicable      Due
                            ----------      ---
Hep C Risk Factor Screen       172           16
Hep C Test for Risk             30            7
Hep C Diagnosis Missed           0            0
Hep C Diagnosis                 36           36
Hep C- Dz & Trans Ed            36           27
Hep C - Eval for Rx             36           15
Chr Hep - Hep A Titer           45            3
Hepatitis A Vaccine             19            4
Chr Hepatitis - AFP             12            4
Chr Hepatitis - U/S             13            6

Report run on 175 patients.
```

Chapter 6: Health Summaries and Clinical Reminders

Health Summaries

Reminder items can be added to health summary displays. Health summaries and reminder definitions can be tailored to suit clinicians' needs.

Health Summary Reminder Components

Reminders Due: an abbreviated component indicating only what is due now.
Reminders Summary: this provides the status, the next due date, and the last done date.
Reminder Maintenance: this component provides:

- Details about what was found from searching the **V***IST***A** clinical data:
- Text related to the findings found or not found (as defined in the reminder). This includes taxonomies (ICD or CPT codes), health factors, and test results related to the reminder and computed findings (e.g., Body Mass Index).
- Final frequency and age range used for the reminder.

NOTE: Statuses include "DUE SOON," to allow you to process a reminder in advance, if convenient.

Example of *Reminder Due* as displayed on a health summary

```
                                --STATUS-- --DUE DATE--  --LAST DONE--
Advanced Directives Education     DUE NOW     DUE NOW       unknown
Alcohol Abuse Education           DUE NOW     DUE NOW       unknown
```

Example of Reminder Summary as displayed on a health summary

```
                               --STATUS--  --DUE DATE--  --LAST DONE--
Mammogram                       RESOLVED    05/01/2003    10/01/2002
Pap Smear                       DUE NOW     06/01/2003      unknown
Diabetic Eye Exam               DUE NOW     06/01/2003     06/01/2002
```

Example of Reminder Maintenance as displayed on a health summary

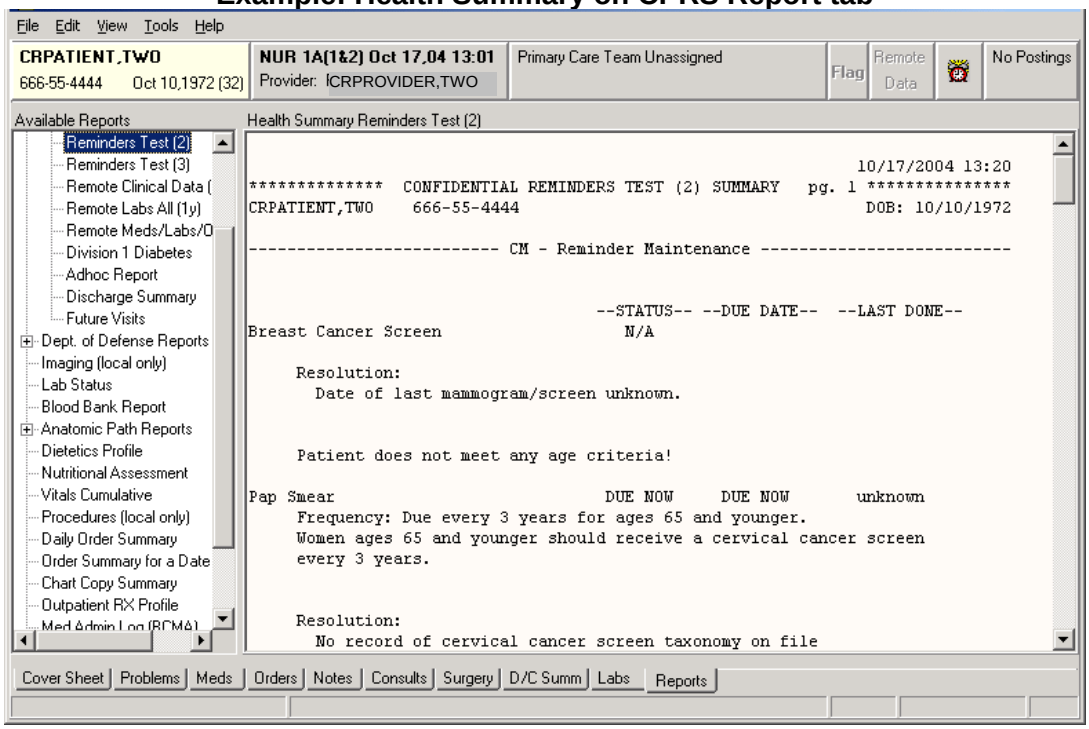
```
------------------------- CM - Reminder Maintenance ----------------------
                                  --STATUS-- --DUE DATE--  --LAST DONE--
Fecal Occult Blood Test            DUE NOW     DUE NOW       unknown
     Applicable: Due every 1 year for ages 50 and older.
     No HX of colorectal cancer on file - presumed no HX.

Health Factor Test                 DUE NOW     DUE NOW       unknown
     Applicable: Due every 1 year for ages 40 to 60.
      Baseline set to 1Y for 40-60.
```

Chapter 6: Health Summaries, cont'd

Health Summary on Reports Tab in CPRS

When you open the Reports tab, select Health Summary, and then select a Reminders Health Summary Type.

Example: Health Summary on CPRS Report tab



Chapter 6: Health Summaries, cont'd

My HealtheVet Health Summary

Clinical Reminders V.2.0 contains new health summary components to support the My Health*e*Vet project. These components will allow display of clinical reminder information to patients.

My Health*e*Vet is a Web-based system that empowers veterans with information and tools so that they can improve their health to the maximum extent possible. Participating veterans are given copies of key portions of their electronic health records.

NOTE:

The veteran's private health record will be securely stored and only accessible by the veteran and others they have identified.

New health summary components were devised that eliminate much of the technical text and code information that is contained in the CM component. These components will be used to display summary and detailed information on individual patient reminders to the patients from within My Health*e*Vet. They can be also used in other health summaries at a facility if it is useful for display to users at the site.

Chapter 6: Health Summaries, cont'd

My HealtheVet Health Summary

Two new national Health Summary types were created to include the new health summary components:

- REMOTE MHV REMINDERS DETAIL
- REMOTE MHV REMINDERS SUMMARY

These will be available in health summaries on the reports tab in CPRS. Use of these health summaries will allow anyone to view the reminders and text that are being displayed to the patients, even if the patient is being seen at a different site.

Example: MHVS Health Summary

```
                                                                  10/06/2004 08:55
************  CONFIDENTIAL REMOTE MHV REMINDERS SUMMARY  SUMMARY  ************
CRPATIENT,ONE    000-31-9898          1A(1&2)                      DOB: 07/13/1950

--------------------------- MHVS - Summary Display --------------------------

                                    --STATUS-- --DUE DATE--  --LAST DONE--
Flu vaccine                          DUE NOW     DUE NOW       unknown
      Please check these web sites for more information:
      Web Site: CDC Influenza Home Page
      URL: http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm

      Web Site: Weekly Update on Influenza Rates
      URL: http://www.cdc.gov/ncidod/diseases/flu/weekly.htm
       CDC Site for weekly updates on the current influenza activity in the
       community.

      Web Site: Dept HHS Information on Influenza Vaccination
      URL: http://odphp.osophs.dhhs.gov/pubs/guidecps/text/CH66.txt

      Web Site: California Influenza Information
      URL: http://www.dhs.ca.gov/ps/dcdc/VRDL/html/Flutable02-03.htm

      Web Site: Patient Handout for Influenza Vaccine
      URL: http://www.cdc.gov/nip/publications/VIS/vis-flu.pdf
```

Chapter 6: Health Summaries, cont'd

My HealtheVet Health Summary, cont'd

The components can also be used in other health summaries at a facility if it is useful for display to users at the site

Example: MHVS Health Summary, cont'd

```
Flu vaccine Due Now                  DUE NOW     DUE NOW       unknown
     This is the summary patient cohort found text.

     This is the summary resolution not found text.

      Please check these web sites for more information:
      Web Site: CDC Influenza Home Page
      URL: http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm

      Web Site: Weekly Update on Influenza Rates
      URL: http://www.cdc.gov/ncidod/diseases/flu/weekly.htm
       CDC Site for weekly updates on the current influenza activity in the
       community.

      Web Site: Dept HHS Information on Influenza Vaccination
      URL: http://odphp.osophs.dhhs.gov/pubs/guidecps/text/CH66.txt

      Web Site: California Influenza Information
      URL: http://www.dhs.ca.gov/ps/dcdc/VRDL/html/Flutable02-03.htm

      Web Site: Patient Handout for Influenza Vaccine
      URL: http://www.cdc.gov/nip/publications/VIS/vis-flu.pdf
```

Chapter 7: VA-Geriatric Extended Care (GEC) Referral

Important:

This GEC screening tool is for the purpose of evaluating a patient's needs for extended care and is not to be used as the document to refer or place a patient. The document should be part of a packet of information obtained when placing a patient.

Four different disciplines should complete the screening, making it less burdensome on any one individual.

VA-Geriatric Extended Care Referral

Overview

Clinical Reminders V.2.0 includes a nationally standardized computer instrument called VA Geriatric Extended Care (GEC), which replaces paper forms for evaluating veterans for extended care needs. Paper forms that facilities use include VA Form 10-7108, VA Form 10064a-Patient Assessment Instrument (PAI), and VA Form 1204-Referral for Community Nursing Home Care (others sites use various instruments including consults).

The GEC Referral is comprised of four reminder dialogs: VA-GEC SOCIAL SERVICES, VA-GEC NURSING ASSESSMENT, VA-GEC CARE RECOMMENDATIONS and VA-GEC CARE COORDINATION. These dialogs are designed for use as Text Integration Utility (TIU) templates to enter data regarding the need for extended care. Data entered via the dialogs are captured as health factors to be used for local and national reporting.

Since GEC dialogs should only be used as TIU templates, we recommend that the GEC dialogs not be added to the Reminders drawer in CPRS.

The software also includes a new report menu that may be used for local analysis.

Chapter 7: GEC, cont'd

VA-Geriatric Extended Care (GEC)

GEC Health Factors

The GEC Referral project distributes a large set of national health factors that establish a standard set of screening data, to be used across the Veterans Health Administration, and to allow national roll-up during a later phase of the project.

Once data is entered through the TIU dialog templates, the health factor data is stored in the Patient Care Encounter (PCE) files. Extracting, viewing, and managing this set of data requires the GEC dialogs to remain as they are released. Consequently, GEC national reminders cannot be copied, including Reminder Dialogs, Dialog Groups, and Dialog Element levels.

To accommodate local business practices, sites will be permitted to add locally created health factors to the GEC dialogs. The LM Dialog Editor (Dialog Edit List) will display differently when editing national dialogs which have been locked.

Chapter 7: GEC, cont'd

TIP:
NOTE: The GEC Status Indicator is used to control the bundling of GEC data for reporting purposes and does not alter the behavior or actions of either Text Integration Utility or Patient Care Encounter.

GEC Status Check

There is no limit to the entry of GEC Referral data. Since there may be multiple entries of the same health factors over time, and since the data is entered via separate dialogs, extraction and viewing requires the data to be discretely identified. The GEC software depends upon the user to indicate when the data from a given referral should be concluded. The referral is finalized using a new feature called the GEC Status Indicator. This indicator is presented to the user as a dialog at the conclusion of the VA-GEC CARE COORDINATION dialog. It will prompt the user to indicate the conclusion of the Referral with a Yes or No response and will list any missing dialogs. If Yes is selected, the data for the current episode of the Referral is closed. If No is selected, the Indicator is displayed and the data entered will be included with the current episode of the Referral. The Indicator will then be displayed with each succeeding GEC dialog until Yes is selected.

To assist the ongoing management of completing GEC Referrals, the GEC Status Indicator may be added to the CPRS GUI Tools drop-down menu. It may be set at the User or Team level. If added to the drop-down menu, the Indicator may be viewed at any time and used to close the referral if needed. *See your CAC or the Clinical Reminders V. 2.0 Setup Guide for instructions on adding this to the Tools menu.*

GEC dialogs also contain a checkbox called "CHECK TO SEE REFERRAL STATUS." This checkbox appears on all dialog boxes and lets you see a real-time view of the current Referral's dialog-completion status. It presents information similar to that found on the GEC Referral Status Display and can be used to determine if the Referral can be finalized.

Chapter 7: GEC, cont'd

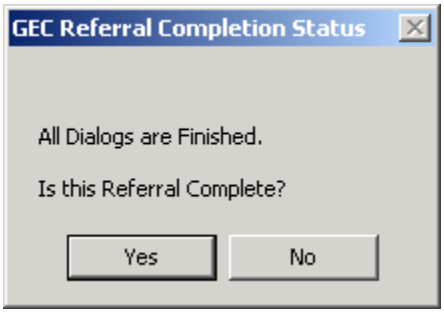
VA-Geriatric Extended Care (GEC) Referral

GEC Status Check
Status Indicator Instructions, cont'd

The Yes button should only be selected if the user is certain no changes are needed and they are ready to commit to the note's authentication. The Status Indicator does not update after the referral has been completed. Put another way, once a referral has been closed, it cannot be reopened. This same risk exists if a note is deleted after the Yes button has been selected and the user then reenters the dialog.

Users should *always* check the Status Indicator when a new referral is initiated on a patient. Doing so will provide the opportunity of closing any previous referral inadvertently left open.

Example of Status Indicator when all dialogs are complete.

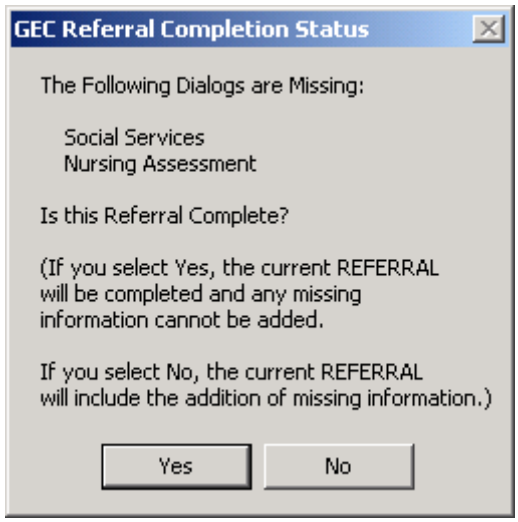


Chapter 7: GEC, cont'd

VA-Geriatric Extended Care (GEC) Referral

GEC Status Check
Status Indicator Instructions, cont'd

Example of Status Indicator when some dialogs are missing.



GEC Referral Ad hoc Health Summaries

Two new health summary components have been created and distributed with this software:

- GEC Completed Referral Count (GECC)
- GEC Health Factor Category (GECH)

The first displays all GEC referral data according to the occurrence and time limits identified. The GEC Health Factor Category component, in conjunction with PX*1*123 and GMTS*2.7*63, permits GEC data to be viewed by health factor or health factor category. If a user should have access to these GEC reports, they must have access to the Ad Hoc Health Summary type. (This can be set using GMTS GUI HS LIST PARAMETERS.)

Chapter 7: GEC, cont'd

VA-Geriatric Extended Care (GEC) Referral

GEC Referral Reminders and Dialogs

The GEC reminders are comprised of dialogs and health factors only. They have neither cohort nor resolution logic, and will not become due. They are intended only as TIU templates and do not need to be assigned to the CPRS Cover Sheet. Due to potential complications with reporting and duplicate entries, it is recommended that the GEC dialogs not be added to the Reminders drawer/Cover sheet. The Referral was designed for inter-disciplinary use with dialogs created for separate services. However, a single user may perform them all. With only a few exceptions, each section of the dialogs is mandatory and is marked with an asterisk (*). The completion of all four dialogs constitutes a discrete episode of the GEC Referral.

The VA-GEC REFERRAL SOCIAL SERVICES, VA-GEC REFERRAL NURSING ASSESSMENT, and VA-GEC REFERRAL CARE RECOMMENDATIONS dialogs comprise the clinical screening. The VA-GEC REFERRAL CARE COORDINATION dialog is used administratively to record the arrangement of and funding for extended care services. These dialogs may be performed in any order that local practices dictate. However, it is expected the screening portion will be completed prior to the coordination of services. When the screen is complete, a consult order should be placed to the service responsible for arranging services.

GEC Consult Order

Most sites have either an individual or a service responsible for arranging and coordinating extended care services. To accommodate local business practices and flexibility, sites may associate any consult service (or menu) they already have in place. If none exist, the sites may create a consult or establish some alternative practice to ensure that both services are arranged and that the VA-GEC REFERRAL CARE COORDINATION dialog is completed.

Sites will need to review the privileging status of those performing the GEC Referral. The staff assigned to place the consult order associated with the GEC dialogs will require the ability to place a consult order. (signature or release).

Chapter 7: GEC Usage, cont'd

TIP:

Refer to Appendix C in the TIU/ASU Implementation Guide for complete instructions about Interdisciplinary Notes

GEC Referral Reports

The software includes a new set of reports that provide a variety of GEC health factor perspectives. They may be assigned as necessary., and will likely be added to the Clinical Reminders Manager Menu in List Manager. The reports capture data elements for reporting and tracking use of the GEC Referral Screening Tool. The reports may be generated in formatted or delimited output. The Summary (Score) report provides summary (calculated) totals from specific sections of the screening tool identified by the Office of Geriatrics Extended Care.

GEC Interdisciplinary Notes

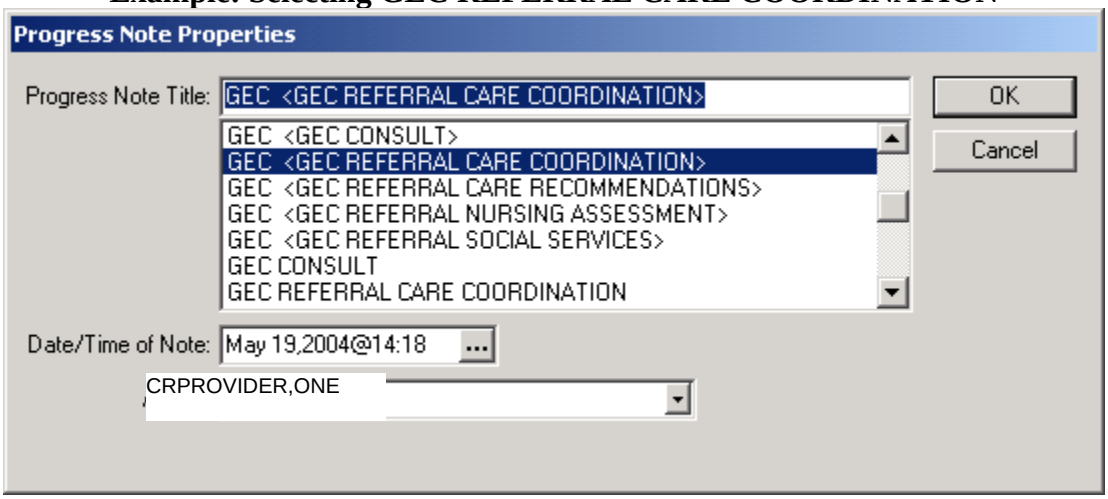
The GEC Referral dialogs are intended for use as TIU templates. It is also expected that they will be used as part of a TIU Interdisciplinary (ID) note. The Office of Geriatrics Extended Care requests that the parent ID note title be:

"GEC EXTENDED CARE REFERRAL"

Steps to the GEC Dialog templates:

1. In the CPRS GUI, open the NOTES tab.
2. Click on New Note.
4. When the Progress Note Properties box opens, type GEC in the Title box.
5. The list of GEC dialog templates is displayed.
6. Select the first one to process.

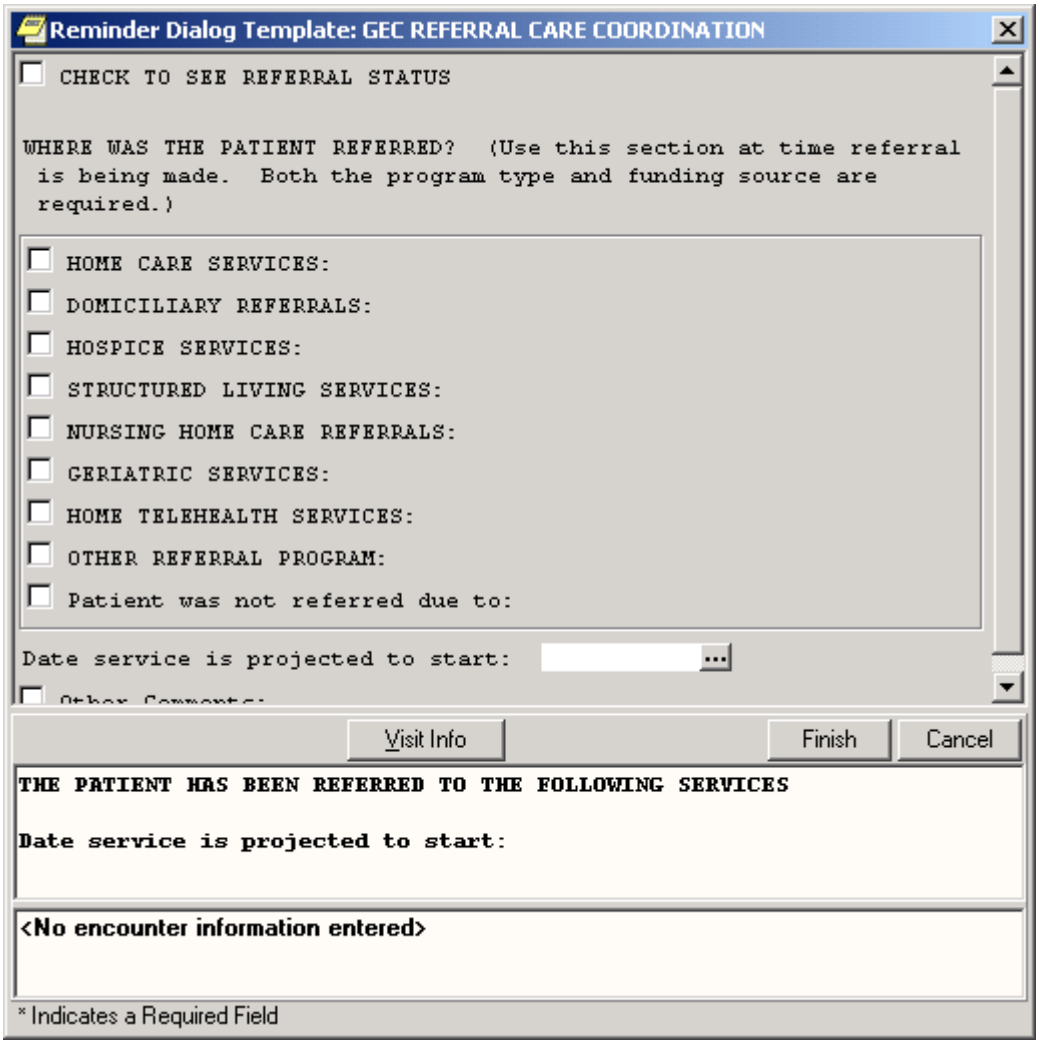
Example: Selecting GEC REFERRAL CARE COORDINATION



Chapter 7: GEC Usage, cont'd

This is first screen shot when you select GEC REFERRAL CARE COORDINATION. When you select one type of service, the screen for that service type expands. The next screen shots show each in expanded form.

Example: GEC REFERRAL CARE COORDINATION Opening screen

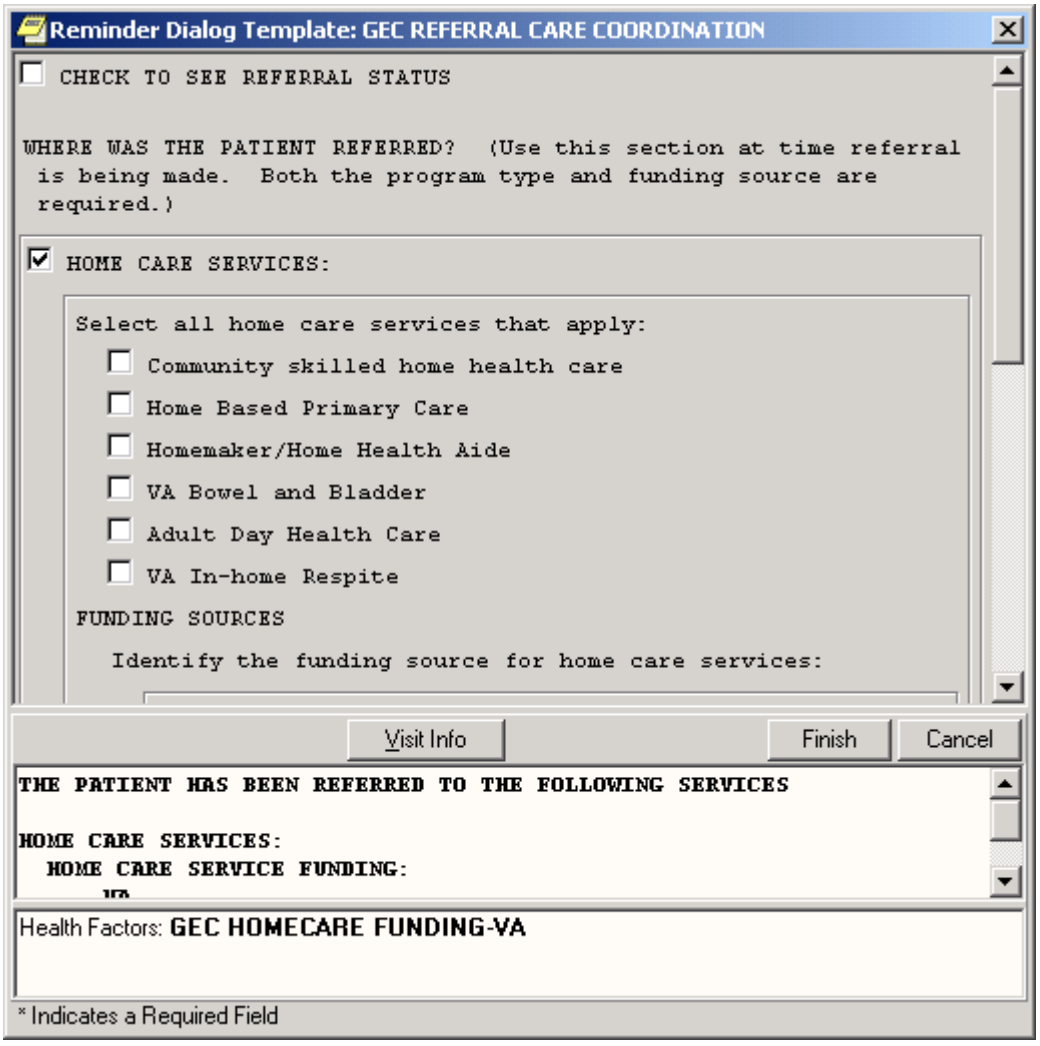


Chapter 7: GEC Usage, cont'd

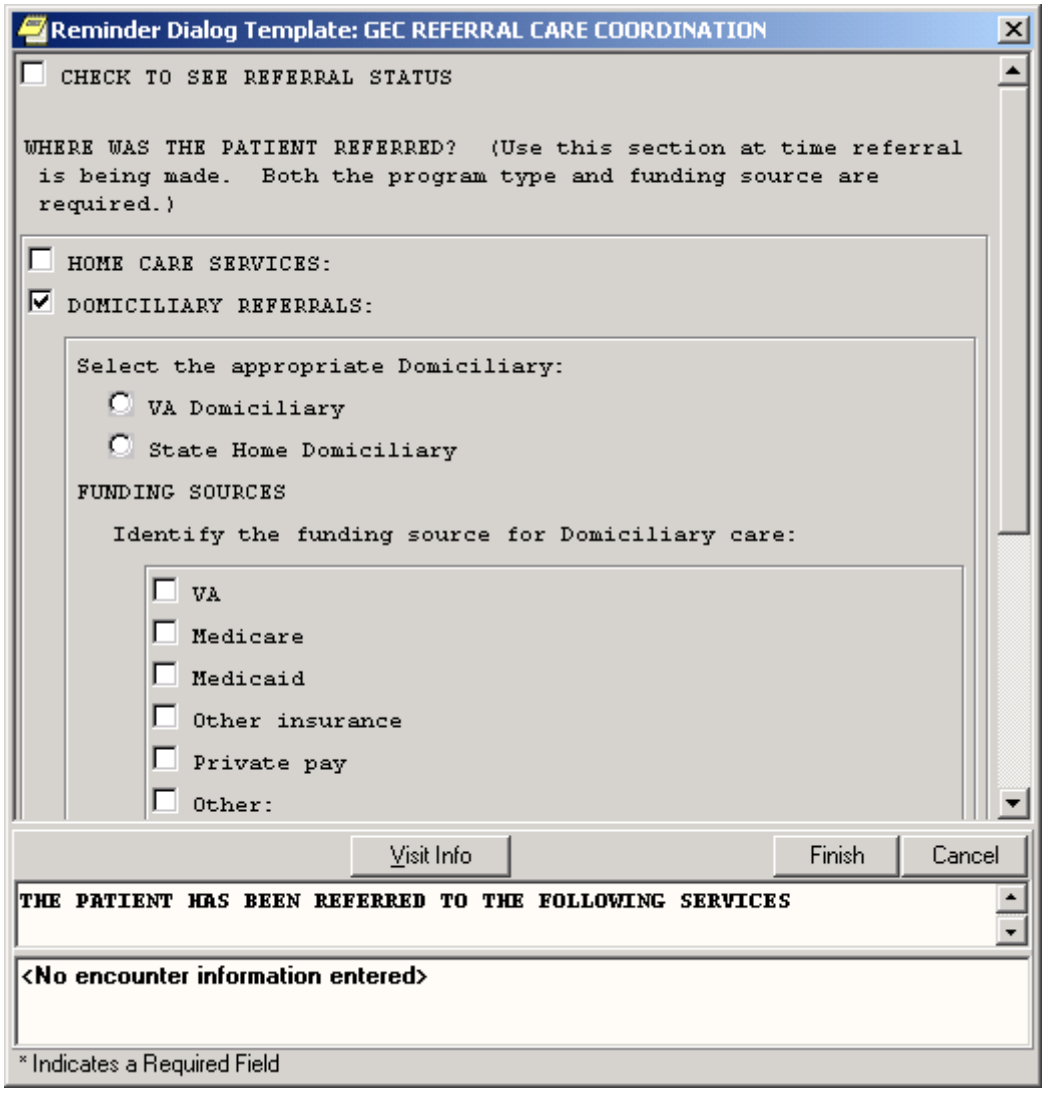
This is the expanded screen when you select HOME CARE SERVICES in the GEC REFERRAL CARE COORDINATION dialog.

Note the checkbox "CHECK TO SEE REFERRAL STATUS." This is available on all dialog boxes and lets you see a real-time view of the current Referral's dialog-completion status. It presents information similar to that found on the GEC Referral Status Display and can be used to determine if the Referral can be finalized.

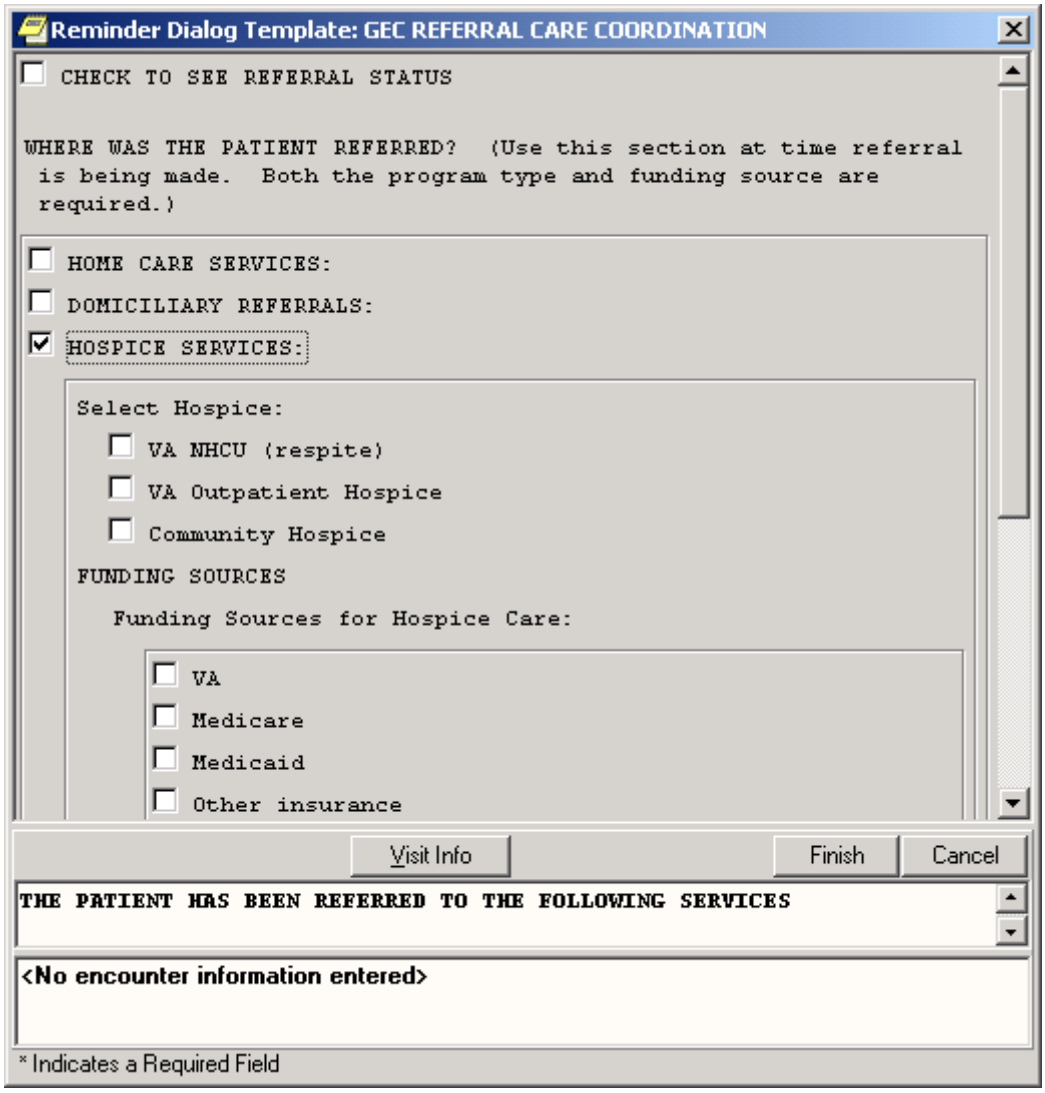
Example: Expanded screen for HOME CARE SERVICES



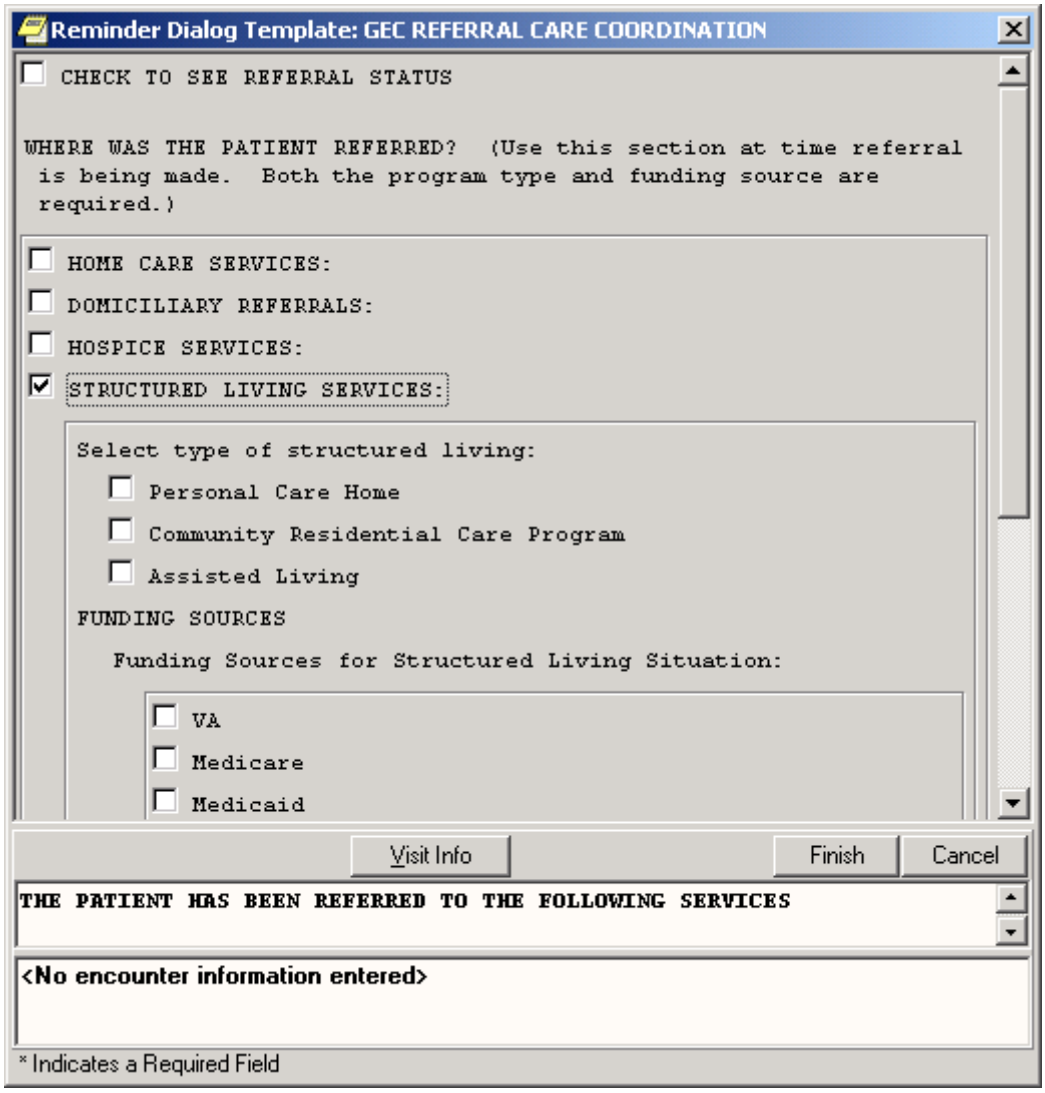
Example: Expanded screen for DOMICILIARY REFERRALS



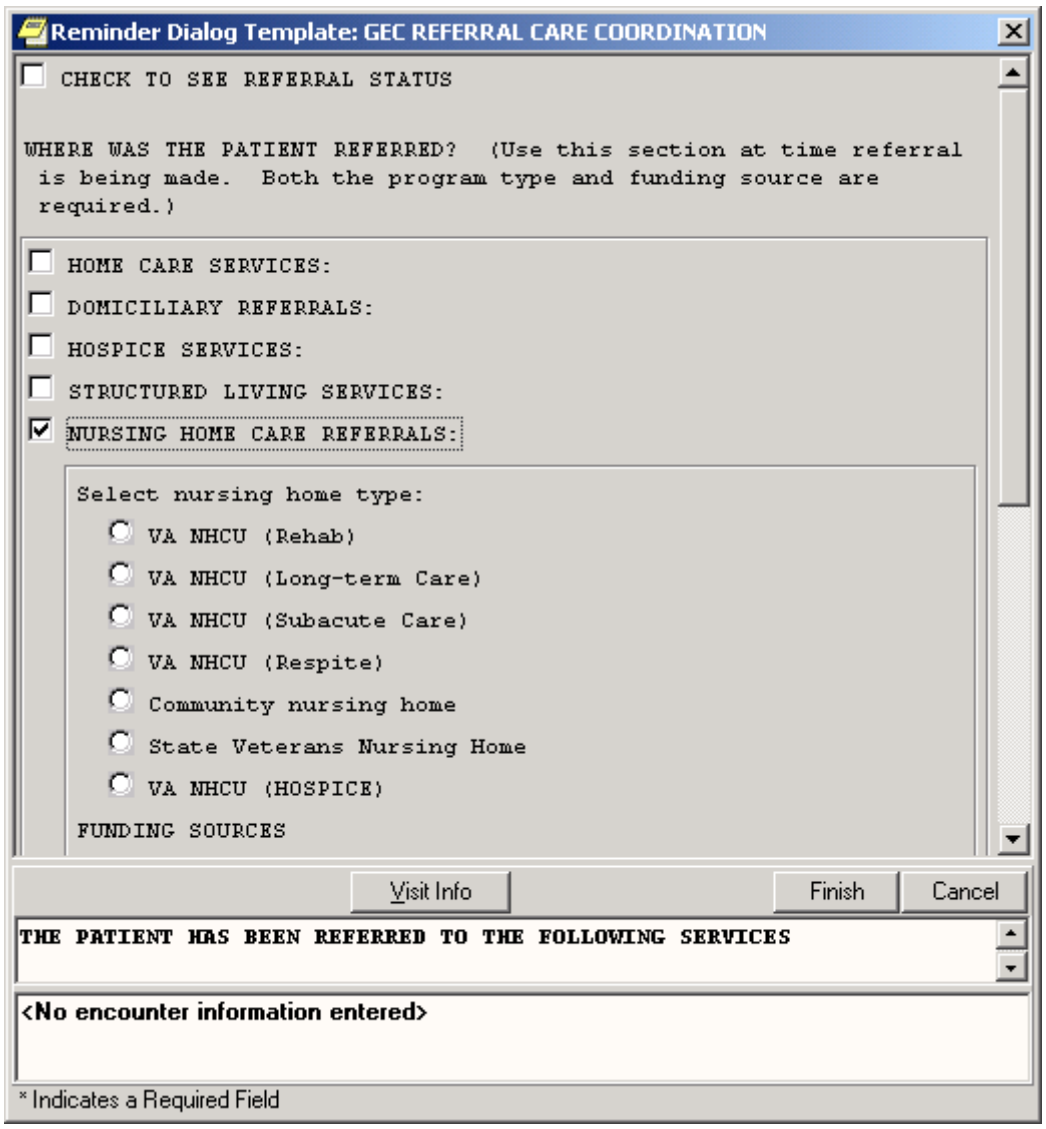
Example: Expanded screen for HOSPICE SERVICES



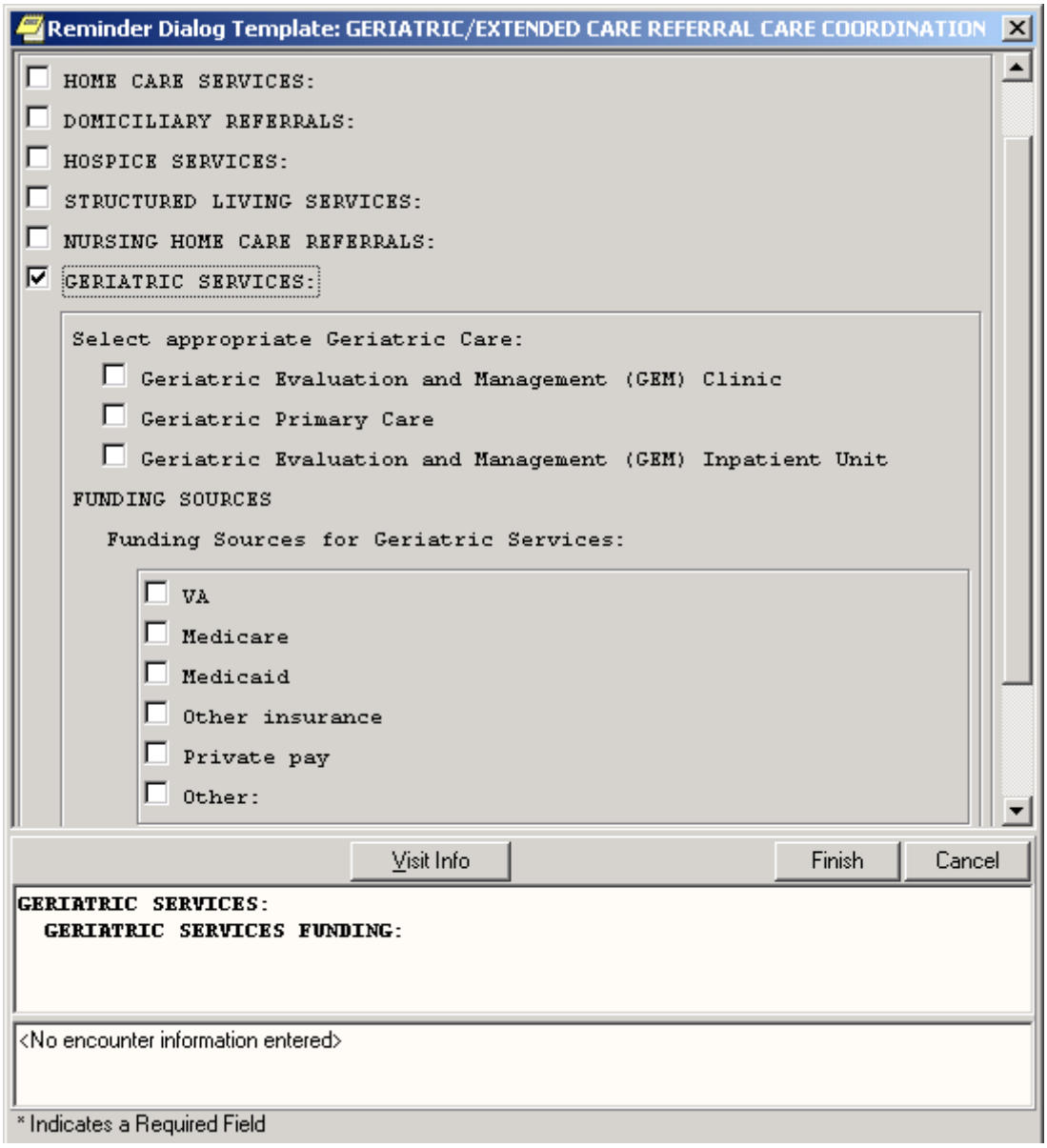
Example: Expanded screen for STRUCTURED LIVING SERVICES



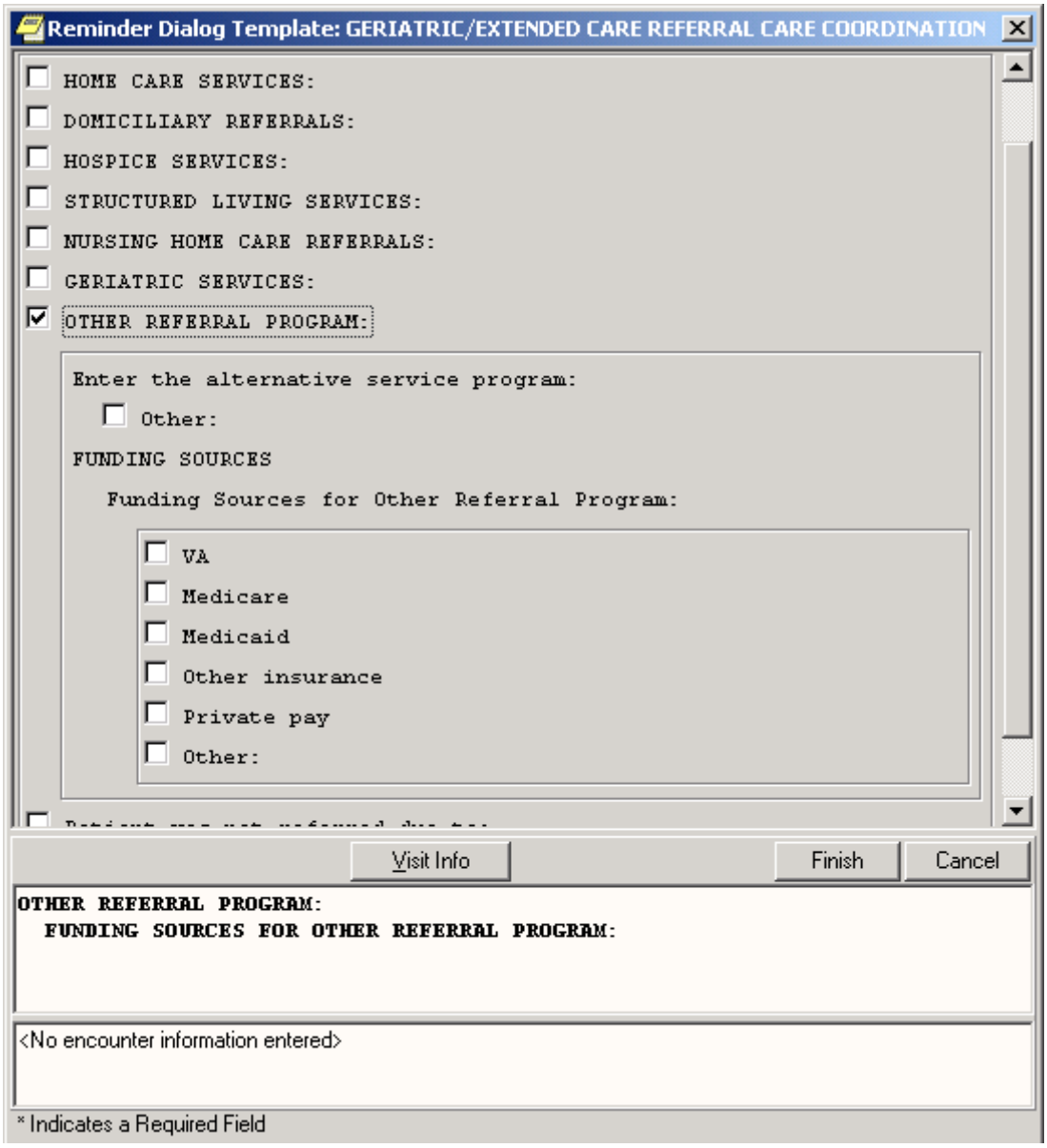
Example: Expanded screen for NURSING HOME CARE REFERRALS



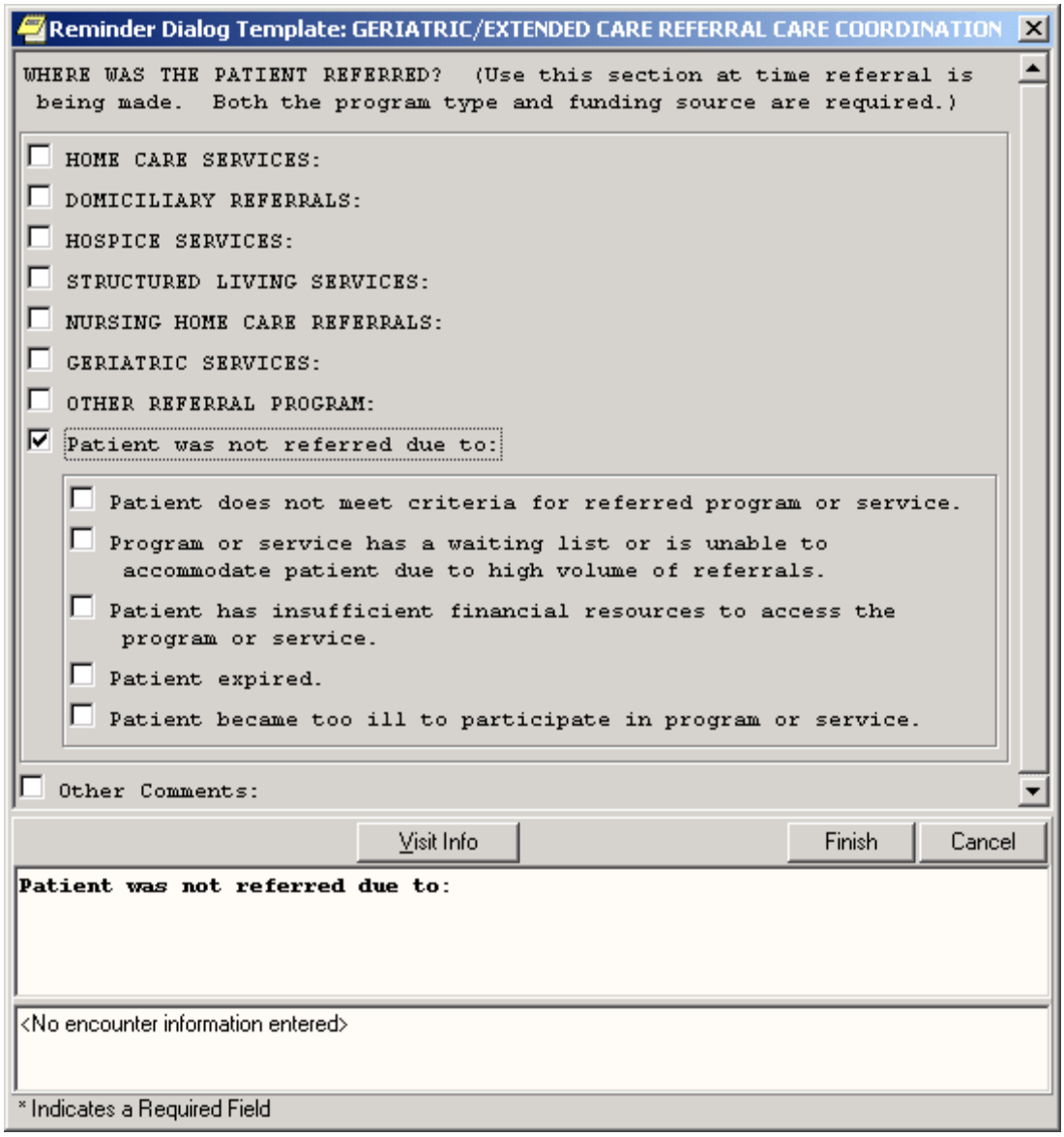
Example: Expanded screen for GERIATRIC SERVICES



Example: Expanded screen for OTHER REFERRAL PROGRAM



Example: Expanded screen for "Patient was not referred due to:"



Chapter 8: Code Set Versioning

NOTE:

The Code Text Descriptors project, released in October 2004, is a follow-up project to Code Set Versioning. It ensures that the diagnostic and procedure descriptions used for billing purposes must be the descriptors that were applicable at the time the service was provided.

It doesn't affect Clinical Reminders.

Chapter 8: Code Set Versioning (CSV) Changes in Reminders

Several changes and enhancements are included in Clinical Reminders V.2.0 in support of Code Set Versioning, mandated under the Health Information Portability and Accountability Act (HIPAA). The changes will insure that only active, on the encounter date, ICD9, ICD0, and CPT codes are selectable in the CPRS GUI application while using Clinical Reminder Dialogs. It will also produce several email messages to Clinical Reminder Managers to help in deciding the correct usage of these codes in the Taxonomies and Dialogs.

PXRM*1.5*18, which contained the CSV changes, was previously released in conjunction with CSV_UTIL v1, Code Set Versioning, which contains routines, globals, and data dictionary changes to recognize code sets for the International Classification of Diseases, Clinical Modification (ICD-9-CM), Current Procedural Terminology (CPT) and Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). When implemented, the Lexicon will allow translation of these three code systems to select codes based upon a date that an event occurred with the Standards Development Organization (SDO) established specific code that existed on that event date.

Version 2.0 of Clinical Reminders includes all of the CSV changes contained in patch 18.

Chapter 9: My HealtheVet

Chapter 9: My HealtheVet Changes in Reminders

Clinical Reminders V. 2.0 contains new health summary components to support the My HealtheVet project. These components will allow display of clinical reminder information to patients. New health summary components were devised that eliminate much of the technical text and code information that is normally displayed for clinicians. These new components will be used to display summary and detailed information on individual patient reminders to the patients from within My HealtheVet. They can be also used in other health summaries at a facility if it is useful for display to users at the site.

See the section under Chapter 5: Health Summary, for examples and descriptions of My HealtheVet HS components.

My Health Reminders are being developed for veterans to view in their My HealtheVet record. Twelve patient reminders have been created:

- Influenza Vaccine
- Pneumonia Vaccine
- Colorectal Screen
- Mammogram Screen
- Pap Smear Screen
- Three for Diabetes: Eye, Foot and HbAlc (blood glucose)
- Two for lipids: lipid measurement and LDL control
- Hypertension
- BMI

These will be distributed in a subsequent patch (PXRM*2*3).

The veteran will be able to click on a “Details” button to see the details of a reminder – comparable to the Clinical Maintenance screens in CPRS and Health Summary.

Chapter 10: Women's Veterans Health Reminders

Chapter 10: CPRS: Integration with Women's Health

"It is VHA policy to provide a nationwide tracking system to ensure that consistent mammography and cervical screening follow-up is achieved and that patients have been properly notified of the test results." (VHA Directive 98-501 dated November 19, 1998)

To meet the data requirements of this policy, the Women's Health (WH) VistA package was developed. However, none of the information contained within the WH software interfaced with CPRS, so the CPRS Integration with Women's Health project was initiated.

Clinical Reminders patch PXRM*2*1 provides reminders and dialogs that enable CPRS GUI to interface with the Women's Health package. These reminder dialogs will update the WH package at the same time that clinical care is recorded in CPRS GUI, thus eliminating the need for dual data entry. The exchange of data will enable Clinical Reminders to capture a greater percentage of data than is currently entered into the Women's Health VistA package, but still allow continuation of Women's Health Software reporting, tracking, and notification functionality.

Project Goals

- Update Pap Smear and Mammogram screening reminders
- Provide review reminders that store clinical review results in the WH package.
- Provide dialogs for the screening and review reminders that clinicians can use to document pap smear tests and mammogram procedures.
- Result in a signed progress note documenting the WH Mammogram- and Pap Smear-related care and patient notifications.

The Mammogram Screening reminder replaces the following national reminders relating to mammograms and breast cancer screening:

VA-*BREAST CANCER SCREEN - rescinded 02/04/2005
VA-MAMMOGRAM - rescinded 02/04/2005

The Pap Screening reminder replaces the following national reminders relating to PAP smears and cervical cancer screening:

VA-*CERVICAL CANCER SCREEN - rescinded 02/04/2005
VA-PAP SMEAR - rescinded 02/04/2005

Chapter 10: Women's Veterans Health Reminders

NOTE:

See the WH Reminders Install and Setup Guide (PXRM_2_1_IG_PDF.) for complete instructions for setting up the WH reminders application.

Chapter 10: CPRS: Integration with Women's Health, cont'd

Setup and implementation by local team

Sites will need to determine if the review reminders should be used locally. If a site is not set up for automatic update of WH, these reminders will not come due, so releasing the review reminders and dialogs might be confusing.

The VA-WH PAP SMEAR REVIEW RESULTS reminder will only come due if all of the following are true:

- PAP smear results are recorded in the VistA Lab package.
- VistA Lab package uses SNOMED codes.
- WH package has SNOMED codes mapped to the codes used by the VistA Lab package.
- WH parameters are set up to automatically receive VistA Lab results when the PAP smear procedure is verified and released.

The VA-WH MAMMOGRAM REVIEW RESULTS reminder will only come due if all of the following are true:

- Mammogram results are recorded and verified in the VistA Radiology package.
- WH parameters are set up to automatically receive VistA Radiology results when the mammogram procedure is verified and released, and status of received mammogram result is set to OPEN.

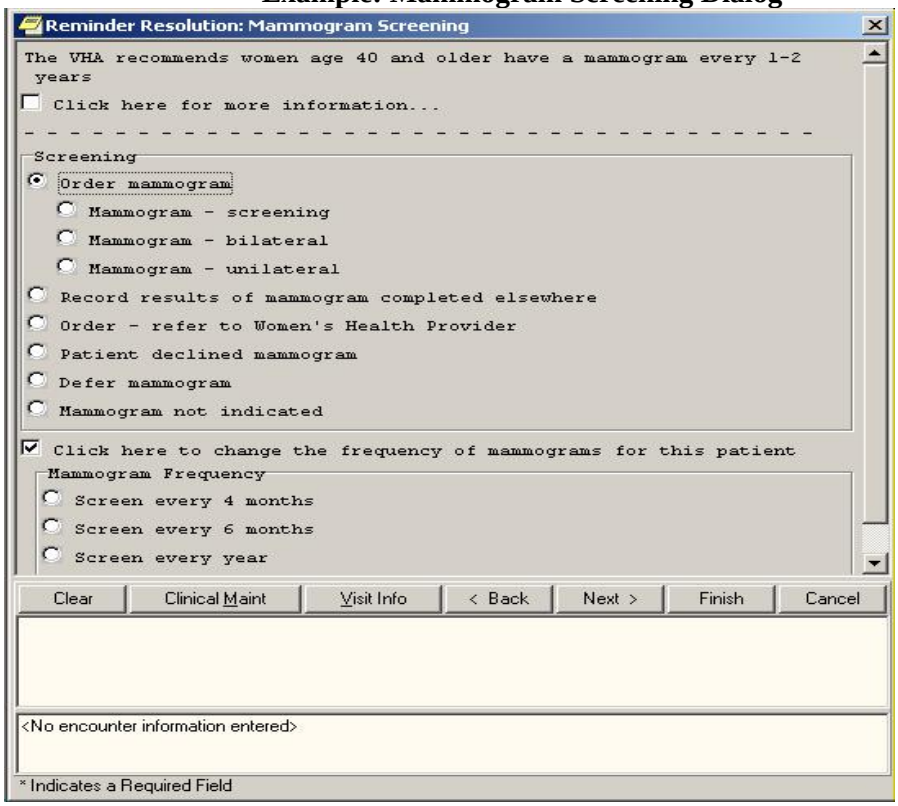
Chapter 10:
Women's Veterans Health Reminders

You can see more information about the guidelines that the reminder is based on by clicking the top checkbox in the dialog.

Steps to use dialogs:

1. On the CPRS cover sheet, click on the Reminders icon.
2. Click on reminders in the Reminders box to see details of a reminder.
3. Open the Notes tab and select New Note. Enter a title.
4. Open the Reminders drawer and review the contents.
5. Locate the Mammogram or Pap reminder you wish to complete (e.g., VA-WH Mammogram Screening) and click to open it.
6. In the dialog box, check relevant actions.
7. Finish the reminder processing.
8. Review the text added to the note to assure its correctness.
9. Ensure that the reminder can be satisfied by the individual finding items that were mapped to the reminder terms.

Example: Mammogram Screening Dialog



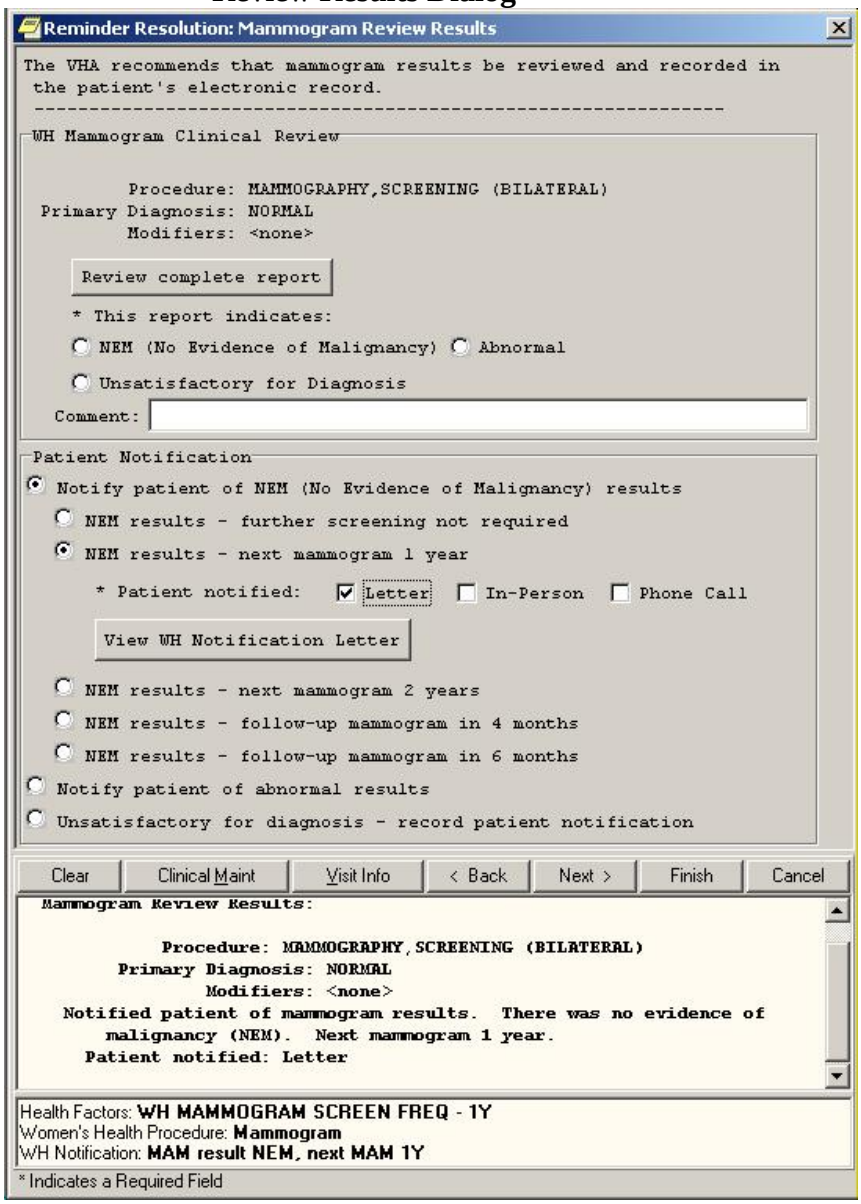
Chapter 10:
Women's Veterans Health Reminders

The notification letter can be modified at your local site.

Review Results Dialogs

If your site uses the Women's Health package, you can review the results of pap smear lab tests or mammogram procedures. You can then send notifications to patients to inform them of the results. The example below shows the Mammogram Review Results dialog and demonstrates sending a notification letter indicating that there is no evidence of malignancy. A follow-up mammogram can be scheduled.

Review Results Dialog



Appendix A: FAQS, Hints, and Tips

Q: Are the reminders our site has already defined compatible with the new Clinical Reminders V. 2.0 package?

A: Yes, a conversion utility is run when the package is installed that converts your reminders to the new file structure. Some reminders may need slight adjustments to work with the new functionality so if you notice any reminders the don't seem to be working correctly notify your reminder manager.

Q: If orders are included in dialogs and I check these through the Notes tab in CPRS, are the orders actually placed, or is this just recording the intention to order something?

A: The order is actually placed, just as if you had ordered through the Orders tab. If the order is set up as a quick order, it will go through immediately (when you click the Finish button); if not a quick order, further questions will be asked to complete the order. The order will still need to be signed.

Q: When I click on a reminder to process, I get a message saying "no dialog is defined for this reminder." What does this mean and what do I need to do?

A: See your CAC or Clinical Reminders manager. They need to create and link a dialog for this reminder.

Q: What do clinicians need to learn to use Clinical Reminders functionality?

A: The most important things to learn will be related to changes in workflow. It will be important to coordinate orders that are placed through reminder dialogs with nurses and clerks. You can work with your CACs and teams to share the responsibility for reminders so that no individual is overwhelmed with reminders. Also, learning to use reports correctly to produce meaningful data will be essential.

Appendix A: FAQS, Hints, and Tips

Q: Is there any way to do a reminder report on an individual finding item?

We want to add a check box that indicates depression is a new diagnosis. Is there a way to do a reminder report just on that one finding that will tell us how many of the patients that were seen that this was applicable for?

A: Set up a local reminder with that one finding as a resolution finding. Define the reminder USAGE field as Reports, and then it will not appear on the cover sheet.

Additional trick:
Make the frequency to be 1 day, and put an OR for the resolution logic and AND for the COHORT logic. That then gives you output in the CM or health summary that gives the date it was last done so not only do you get a list of folks who have the finding but you also can tell when it was entered.

Q: When Clinical Maintenance is run on a reminder that is applicable due to a problem list entry, why is today's date pulled rather than the date of problem list entry?

A: There are two dates associated with ICD9 diagnoses found in PROBLEM LIST. There is the date entered and the date last modified. The PRIORITY field is used to determine if a problem is chronic or acute. ***If the problem is chronic, Clinical Reminders will use today's date in its date calculations; otherwise it will use the date last modified.*** Note that it only uses active problems unless the field USE INACTIVE PROBLEMS is yes.

Q: I opened the Reminders Drawer and all my reminders have disappeared, what do I do?

A: Check your View list (Appendix D); most likely nothing will be checked. Select the reminder categories you want displayed and click on them so the checkmark is displayed.

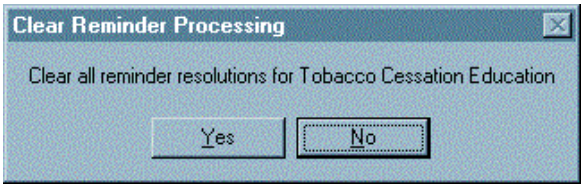
Appendix A: FAQS, Hints, and Tips

Tips

Clearing a Single Reminder

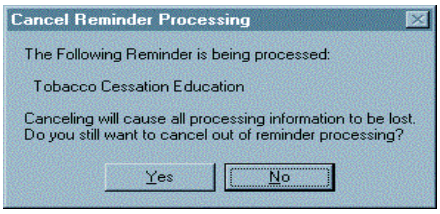
You will probably process several reminders for a single visit. If you have entered information on a reminder, but you need to start over on that reminder only, you can click Clear on the reminder from the Reminders Drawer, and then click the Clear button in the Reminders dialog box. This removes all previous dialog selections from the reminder's dialog box and removes the related text and data from the Progress Note Text box and the PCE data box for this reminder. You can now start processing again.

NOTE: Clicking Clear will remove the information from only one reminder. Be careful that you are on the correct reminder before you click Clear.



Canceling Out of the Processing Dialog

If you reach the Reminders processing dialog by mistake or you wish to delete information that you have entered and start over, click Cancel.



Appendix B: Glossary

Acronyms

AAC	Austin Automation Center
AIMS	Abnormal Involuntary Movement Scale
API	Application Programmer Interface.
CAC	Clinical Application Coordinator
CPRS	Computerized Patient Record System.
DBIA	Database Integration Agreement.
EPRP	External Peer Review Program
EVS	Enterprise VistA Service
GEC	Geriatric Extended Care
GUI	Graphical User Interface.
HSR&D	Health Services Research and Development
HL7	Health Level 7
IHD	Ischemic Heart Disease
LDL	Low-density lipo-protein
MDD	Major Depressive Disorder
MH	Mental Health
MHV	My HealtheVet
OQP	Office of Quality and Performance
PCE	Patient Care Encounter
QUERI	Quality Enhancement Research Initiative
SAS	Statistical Analysis System
SQA	Software Quality Assurance
SRS	Software Requirements Specification
TIU	Text Integration Utilities
VHA	Veterans Health Administration.
VISN	Veterans Integrated Service Networks.
VIS*TA*	Veterans Health Information System and Technology Architecture**.**

National Acronym Directory

Definitions

AAC SAS Files

AAC SAS files contain data that is equivalent to data stored in the Reminder Extract Summary entry in the Reminder Extract Summary file. AAC manages SAS files for use by specifically defined users.

Applicable

The number of patients whose findings met the patient cohort reminder evaluation.

Due

The number of patients whose reminder evaluation status is due.

Appendix B: Glossary

National Database

All sites running IHD and Mental Health QUERI software transmit their data to a compliance totals database at the AAC.

Not Applicable

The number of patients whose findings did not meet the patient cohort reminder evaluation.

Not Due

The number of patients whose reminder evaluation status is not due.

Reminder Definitions

Reminder Definitions comprise the predefined set of finding items used to identify patient cohorts and reminder resolutions. Reminders are used for patient care and/or report extracts.

Reminder Dialog

Reminder Dialogs comprise a predefined set of text and findings that together provide information to the CPRS GUI, which collects and updates appropriate findings while building a progress note.

Reminder Patient List

A list of patients that is created from a set of List Rules and/or as a result of report processing. Each Patient List is assigned a name and is defined in the Reminder Patient List File. Reminder Patient Lists may be used as an incremental step to completing national extract processing or for local reporting needs. Patient Lists created from the Reminders Due reporting process are based on patients that met the patient cohort, reminder resolution, or specific finding extract parameters. These patient lists are used only at local facilities.

Reminder Terms

Predefined finding items that are used to map local findings to national findings, providing a method to standardize these findings for national use.

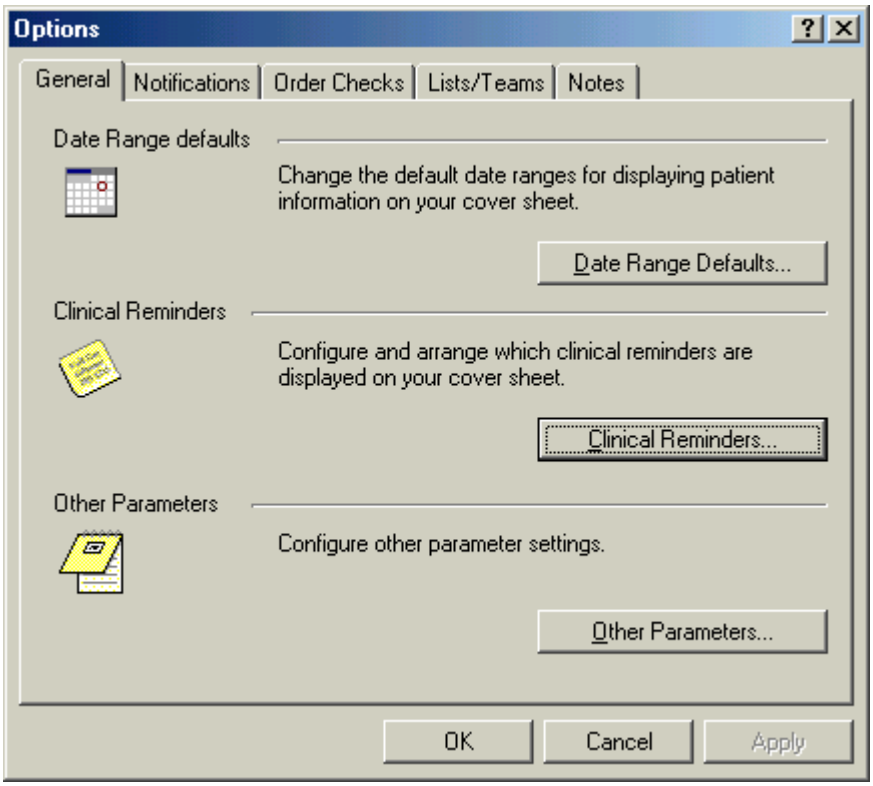
Report Reminders

Reminders may be defined specifically for national reporting. Report Reminders do not have a related Reminder Dialog in CPRS and are not used by clinicians for patient care. However, clinical reminders that are used in CPRS may also be used for national reminder reporting. All reminders targeted for national reporting are defined in Extract Parameters.

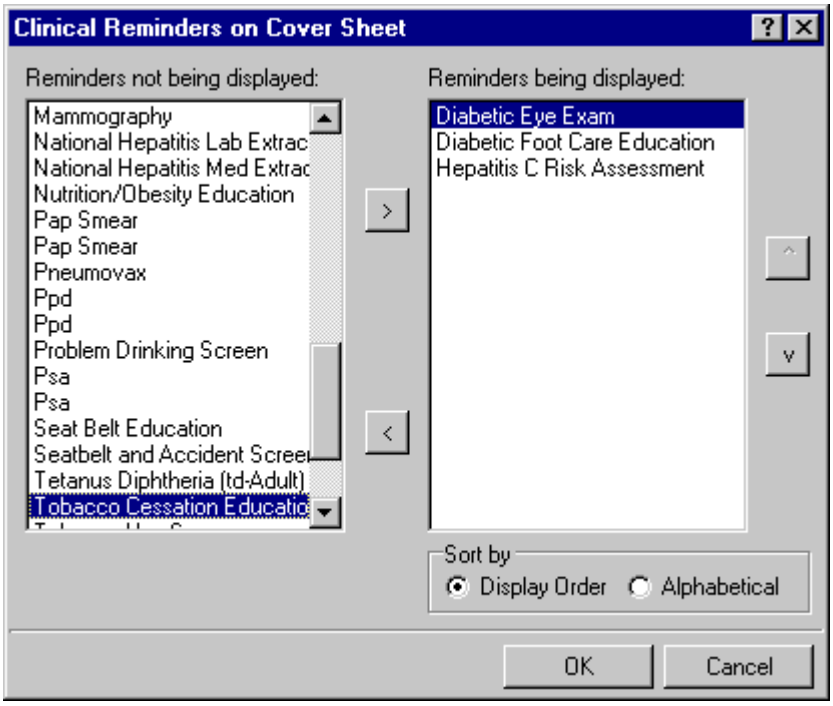
Appendix C: Edit Cover Sheet Reminder List

You can specify which reminders will appear on the cover sheet of CPRS. This is done by using the Edit Cover Sheet Reminder List option.

1. While on the CPRS Cover Sheet, click on the Tools menu.
2. From the drop-down menu that appears, click on Options.
   This screen appears:



3. Click on the Clinical Reminders button to get to the editing form.



4. Highlight an item in the Reminders not being displayed field and then click the Add arrow ">" to add it to the Reminders being displayed field. You may hold down the Control key and select more than one reminder at a time.

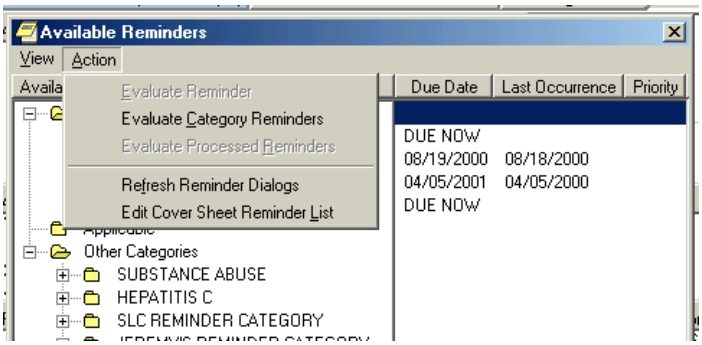
5. When you have all of the desired reminders in the field, you may highlight a reminder and use the up and down buttons on the right side of the dialog to change the order in which the reminders will be displayed on the Cover Sheet.

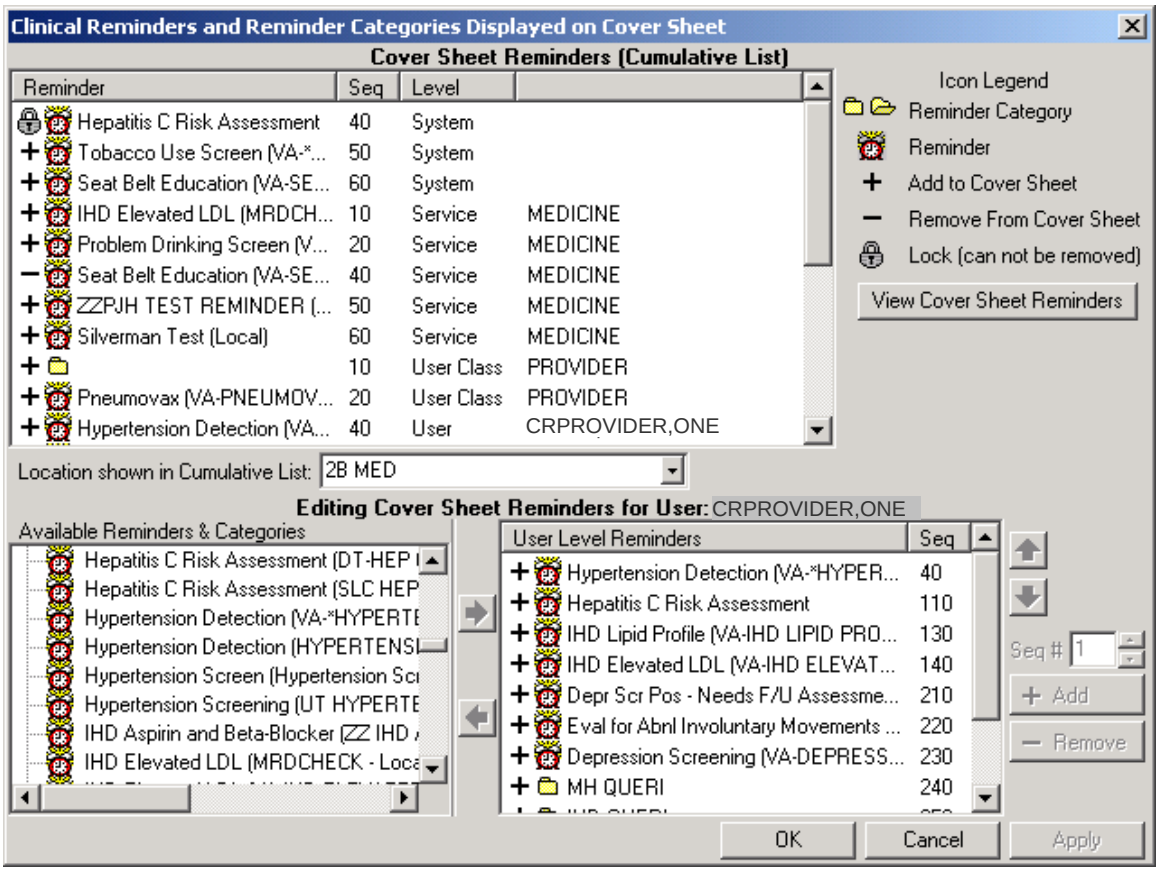
New Reminders Parameters (ORQQPX NEW REMINDER PARAMS**)**

If you have been assigned this parameter, you can also modify the reminders view on the coversheet.

clicking on the reminder button next to the CWAD button in the upper right hand corner of the CPRS GUI.

Click on Action then click on Edit Cover Sheet Reminder List.





This form provides very extensive cover sheet list management capabilities. It consists mainly of three large list areas.

- *Cover Sheet Reminders (Cumulative List)* displays selected information on the Reminders that will be displayed on the Cover Sheet.
- *Available Reminders & Categories* lists all available Reminders and serves as a selection list.
- *User Level Reminders* displays the Reminders that have been added to or removed from the cumulative list.

You may sort the Reminders in *Cover Sheet Reminders (Cumulative List)* by clicking on any of the column headers. Click on the Seq (Sequence) column header to view the Reminders in the order in which they will be displayed on your cover Sheet.

Appendix D: VA GEC Reports

In December 2003, a Healthcare Inspection by the Department of Veteran Affairs Office of Inspector General was conducted on the Homemaker/Home Health Aide Program to evaluate Department of Veteran Affairs (VA) Medical facilities compliance with the Veteran Health Administration (VHA) policy for providing services to patients that were clinically appropriate, cost effective, and met customer expectations. The outcome of that Inspection revealed a lack of supportable data for placement of patients.

As part of the Undersecretary for Health's commitment to complying with VA policy, the need for accurately documenting and reporting patient placements is needed. VA Geriatric Extended Care (VA GEC) Reports will serve as an interim reporting method until the national rollup of VA GEC Referral data is provided through Computerized Patient Record System Reengineered (CPRS-R). VA GEC Reports will display the percent of patients referred to select GEC programs who meet the eligibility criteria as outlined in the Under Secretary for Health's Information Letter IL 10-2003-005 and VHA Handbook 1140.2.

VA GEC Reports will provide quarterly statistical reports on the following VA funded programs.

- Homemaker/Home Health Aide, when Funding Source=VA
- Adult Day Health Care, when Funding Source=VA
- VA In-Home Respite, when Funding Source=VA
- Care Coordination, when Funding Source=VA

Select data from the VA Geriatric Extended Care Referral screening tool, released with Clinical Reminders 2.0, will be used in calculating the criteria totals for patients screened and referred for each of the four programs listed above.

Data Elements for Reporting taken from the VA GEC Referral Screening of the following:

- Source
- Living Situation
- Instrumental Activities of Daily Living
- Basic Activities of Daily Living
- Patient Behaviors and Symptoms
- Cognitive Status
- Prognosis

Data Elements for Reporting taken from Patient File and Scheduling File
Age of Patient is 75 years or greater
Patient Identified as a High Utilizer of Medical Services

Implementation Requirements

The stakeholder will create an Excel spreadsheet for the purpose of importing the data received from the local sites, according to the specifications provided in the Algorithm that follows.
Local sites must task the job by setting the queue to automatically generate the quarterly reports.

The Office of Geriatric and Extended Care is responsible for importing data received, via electronic email, into a GEC created excel spreadsheet.

Product Features

The main feature of this product is the creation of a report that will allow monitoring compliance of VA patients referred to specified VA funded Geriatric Extended Care programs.

- Create a tool that will extract the data on patients meeting the criteria from the VA funded GEC program.
- The extracted data will be emailed to appropriate compliance office.

New Option

GEC Fiscal Quarterly Rollup [PXRM GEC2 QUARTERLY ROLLUP]

This is a queuable option that will gather and report to Washington DC the Fiscal Quarterly information.

This option should never be placed on an individual's menu. It should be scheduled for the 8th day of the first month of the next calendar quarter at any time of the facility's choosing. The rescheduling frequency should be set to "3M" (every three months).

New Mail Group

GEC2 NATIONAL ROLLUP

When this mail group is installed, it will contain the email address of the two individuals in Washington DC who will receive the quarterly data. These names should not be removed. Names of local individuals (for example, CACs) may be added, if they desire to receive these reports.

Important NOTE:

We recommend thorough testing of GEC reminder dialogs by staff prior to implementation to avoid GEC report roll-up inaccuracies. Testing of GEC reminder dialogs and reports in a test account should mimic the actual processes and workload capture used in the site's production environment.

Informatics staff and GEC referral staff should work together to identify potential issues that arise during testing that may require modification of clinical processes and/or workload capture. Accurate capture and reporting of GEC referral health factors may require careful analysis of workload capture processes at sites that use Event Capture software. Inaccurate reporting may lead to questions from the Inspector General's office concerning funding for the patients referred to the "Home Help" type of programs.

Potential issues if you use Event Capture

(reported by a test site):

a) Event capture does not pass workload to PCE in real time. Data is not passed to PCE until after hours, so this needs to be taken into account when testing.

b) There are several steps where real front-line users could make minor mistakes that would result in data entry/workload not matching up with the Care coordination note.
   1. Event capture date/time must be an exact match to the date/time of PCE/TIU
   2. Clinic location must be the same.
   3. Data passes after hours from EC to PCE.
   4. There is no drop-down menu to select from. 1 and 2 above must be manually entered.
   5. Patient name must be re-selected (or use spacebar return).

Algorithm For GEC (Next Generation) Software

The information for the "criteria" is taken from the letter # IL 10-2004-005 entitled UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER dated May 3 2004. pages B-2 and B-3

The following is the Algorithm or thought process that will be used in the software to determine if a patient meets the criteria necessary to be placed in one of the monitored programs. HEALTH FACTORS that are part of the patient record for an evaluation, are designated with capital letters (below).

7D = 7 days
YES or NO = Yes or No response from the Dialog
Additional explanations found to the right of health factor

Initial Requirement is to be referred to one of the following VA funded programs.
(Requires **1** or **6,** plus one of the other Health Factors)

1. GEC ADULT DAY HEALTH CARE (REFERRED TO)
2. GEC HOMECARE FUNDING-VA
3. GEC HOMEMAKER/HOME HEALTH AIDE
4. GEC VA IN-HOME RESPITE
5. GEC HOME TELEHEALTH (REFERRED TO)
6. GEC TELEHEALTH FUNDING-VA

Criteria #1 : "Three or more Activities of Daily Living (ADL) dependencies."
(Any 3 of the ADL's below)

- GEC BATHING HELP/SUPERVISION LAST 7D-YES
- GEC BED POSITIONING HELP LAST 7D-YES
- GEC DRESS HELP/SUPERVISION LAST 7D-YES
- GEC EATING HELP/SUPERVISION LAST 7D-YES
- GEC INDEPENDENT IN WC LAST 7D-YES
- GEC MOVING AROUND INDOORS LAST 7D-YES
- GEC TOILET HELP/SUPERVISION LAST 7D-YES
- GEC TRANSFERS HELP/SPRVISION LAST 7D-YES

OR
Criteria #2 : "Significant cognitive impairment"
(Any 1 of those indicated below)

- GEC CAN BE UNDERSTOOD LAST 7D-NO
- GEC ENDANGERED SAFETY LAST 90D-YES
- GEC MADE REASONABLE DECISIONS LAST 7D-NO
- GEC HALLUCINATIONS/DELUSIONS LAST 7D-YES
- GEC PHYSICALLY ABUSIVE LAST 7D-YES
- GEC RESISTS CARE LAST 7D-YES
- GEC VERBALLY ABUSIVE LAST 7D-YES
- GEC WANDERING LAST 7D-YES

OR
Criteria #3 " Prognosis of Life Expectancy of less than 6 months"
(Any 1 of these health factors)

- GEC LIFE EXPECTANCY < 6MO-YES

OR

Criteria #4 : "Two ADL dependencies and two or more of the following conditions:"

(Any 2 of the ADL's below and the additional requirements)

- GEC BATHING HELP/SUPERVISION LAST 7D-YES
- GEC BED POSITIONING HELP LAST 7D-YES
- GEC DRESS HELP/SUPERVISION LAST 7D-YES
- GEC EATING HELP/SUPERVISION LAST 7D-YES
- GEC INDEPENDENT IN WC LAST 7D-YES
- GEC MOVING AROUND INDOORS LAST 7D-YES
- GEC TOILET HELP/SUPERVISION LAST 7D-YES
- GEC TRANSFERS HELP/SPRVISION LAST 7D-YES

AND

"(a) Dependency in three or more Instrumental ADL (IADL)"

(Any 3 of the IADL)

- GEC DIFFICULT TRANSPORTATION/LAST 7D-YES
- GEC DIFFICULTY MANAGING MEDS/LAST 7D-YES
- GEC DIFFICULTY MNG FINANCES/LAST 7D-YES
- GEC DIFFICULTY PREPARE MEALS/LAST 7D-YES
- GEC DIFFICULTY USING PHONE/LAST 7D-YES
- GEC DIFFICULTY W/ HOUSEWORK/LAST 7D-YES
- GEC DIFFICULTY WITH SHOPPING/LAST 7D-YES

OR

"(b) Recent discharge from a nursing home, or upcoming nursing home discharge plan contingent on receipt of home and community – based care services."

- GEC COMMUNITY NRSNG HOME (REFERRED FROM)
- GEC VA DOMICILIARY (REFERRED FROM)
- GEC VA NURSING HOME

OR

"(c) Seventy Five Years old , or older."

(Obtained from the Patient's Records using an API call)

OR

"(d) High use of medical services defined as **three** or more hospitalizations in the past year and/or utilization of outpatient and/or emergency evaluation units **twelve** or more times in the past year.

(The API ….GETAPPT^SDAMA201(…) to retrieve appointments etc.)

OR

"(f) Living alone in the Community"

- GEC ALONE

Example: Home Health Eligibility Report (All patients)

Use the GEC Referral Report on the Reminder Managers Menu to produce reports.

```
   CF     Reminder Computed Finding Management ...
   RM     Reminder Definition Management ...
   SM     Reminder Sponsor Management ...
   TXM    Reminder Taxonomy Management ...
   TRM    Reminder Term Management ...
   LM     Reminder Location List Management ...
   RX     Reminder Exchange
   RT     Reminder Test
   OS     Other Supporting Menus ...
   INFO   Reminder Information Only Menu ...
   DM     Reminder Dialog Management ...
   CP     CPRS Reminder Configuration ...
   RP     Reminder Reports ...
   MST    Reminders MST Synchronization Management ...
   PL     Reminder Patient List Menu ...
   PAR    Reminder Parameters ...
   XM     Reminder Extract Menu ...
   GEC    GEC Referral Report

You have PENDING ALERTS
          Enter  "VA to jump to VIEW ALERTS option

Select Reminder Managers Menu Option: GEC  GEC Referral Report

All Reports will print on 80 Columns

     Select one of the following:

          1         Category
          2         Patient
          3         Provider by Patient
          4         Referral Date
          5         Location
          6         Referral Count Totals
          7         Category-Referred Service
          8         Summary (Score)
          9         'Home Help' Eligibility

Select Option or ^ to Exit: 8// 9  'Home Help' Eligibility

Select a year for the report (i.e.2005)
YEAR or ^ to exit:  (2004-2030): 2005

Select a Fiscal QUARTER in the year 2005 (i.e.2)
     Fiscal Years start in October.
Fiscal Quarter 1 same as Calendar Quarter 4
Fiscal Quarter 2 same as Calendar Quarter 1
Fiscal Quarter 3 same as Calendar Quarter 2
Fiscal Quarter 4 same as Calendar Quarter 3

Fiscal Quarter or ^ to exit:  (1-4): 2

     Select one of the following:

          A         All Patients
          M         Multiple Patients

Select Patients or ^ to exit: A// <Enter> ll Patients


     Select one of the following:

          Y         YES
```

```
          N         NO

Select Show Test Patients in this Report?
Y or N or ^ to exit: YES
DEVICE: HOME// ;;999  ANYWHERE    Right Margin: 80//

Please wait ...

================================================================================
Referred to Homemaker/Home Health Aide(HHHA) or Adult Day Health Care(ADHC)
or VA In-Home Respite(VAIHR) or Care Coordination programs(CC)
From: 01/01/2005 To: 03/31/2005
Fiscal Quarter: 2 (Calendar Quarter 1)
                                          Criteria              Measured
   Name                  SSN    Prog.  0  #1 #2 #3 #4 Date      Criteria
================================================================================

   CRPATIENT,ONE         C0000  VAIHR  X              01/27/2005 NOT MET
   CRPATIENT,TWO         C6667  CC           X        01/28/2005
   CRPATIENT,THREE       C6668  ADHC         X     X  02/09/2005
   CRPATIENT,FOUR        C6669  ADHC   X             01/31/2005 NOT MET
   CRPATIENT,FIVE        C6660  CC     X             01/27/2005 NOT MET
   CRPATIENT,SIX         C6661  CC     X             01/27/2005 NOT MET
   CRPATIENT,SEVEN       C6668  ADHC         X        01/28/2005
   CRPATIENT,EIGHT       C6663  VAIHR  X             01/31/2005 NOT MET
   CRPATIENT,NINE        C6664  ADHC         X        02/09/2005
   CRPATIENT,TEN         C6670  ADHC               X  02/09/2005
   CRPATIENT,ELEVEN      C6671  CC           X        01/27/2005
   CRPATIENT,TWELVE      C6663  ADHC   X             02/09/2005 NOT MET
   CRPATIENT,THIRTEEN    C6662  VAIHR  X             02/03/2005 NOT MET
   CRPATIENT,THIRTEEN    C6662  ADHC      X  X  X     02/10/2005
   CRPATIENT,THIRTEEN    C6662  ADHC      X  X        02/09/2005
   CRPATIENT,FOURTEEN    C6622  HHHA         X  X     02/03/2005


Criteria
0: Not eligible under any criteria.
1: Problems with 3 or more ADL's.
2: 1 or more patient behavior or cognitive problem.
3: Expected life limit of less than 6 months.
4: Combination of the following:
   2 or more ADL dependencies
   <AND> 2 or more of the following:
         Problems with 3 or more IADL's
     <OR> age of patients is 75 or more.
     <OR> living alone in the community.
     <OR> utilizes the clinics 12 or more time in the
          preceding 12 months.
Enter RETURN to continue or '^' to exit:
```

Example 2: Home Health Eligibility Report (Multiple patients)

This report lets you select individual patient names.

```
Select Reminder Managers Menu Option: GEC  GEC Referral Report


All Reports will print on 80 Columns

     Select one of the following:

          1         Category
          2         Patient
          3         Provider by Patient
          4         Referral Date
          5         Location
          6         Referral Count Totals
          7         Category-Referred Service
          8         Summary (Score)
          9         'Home Help' Eligibility

Select Option or ^ to Exit: 9// 9  'Home Help' Eligibility

Select a year for the report (i.e.2005)
YEAR or ^ to exit:  (2004-2030): 2005

Select a Fiscal QUARTER in the year 2005 (i.e.2)
     Fiscal Years start in October.
Fiscal Quarter 1 same as Calendar Quarter 4
Fiscal Quarter 2 same as Calendar Quarter 1
Fiscal Quarter 3 same as Calendar Quarter 2
Fiscal Quarter 4 same as Calendar Quarter 3

Fiscal Quarter or ^ to exit:  (1-4): 2

     Select one of the following:

          A         All Patients
          M         Multiple Patients

Select Patients or ^ to exit: A// Multiple Patients
Select PATIENT NAME:   CRPATIENT,TWENTY        1-4-07    666003220     YES
SC VETERAN
Select PATIENT NAME:
DEVICE: HOME//   ANYWHERE    Right Margin: 80//

Please wait ...

==========================================================================
Referred to Homemaker/Home Health Aide(HHHA) or Adult Day Health Care(ADHC)
or VA In-Home Respite(VAIHR) or Care Coordination programs(CC)
From: 01/01/2005 To: 03/31/2005
Fiscal Quarter: 2 (Calender Quarter 1)
                                        Criteria
   Name                  SSN    Prog.  0  #1 #2 #3 #4 Date       Not Eligible
==========================================================================

   CRPATIENT,TWENTY     C3220  ADHC         X  X     02/08/2005

Criteria
0: Not eligible under any criteria.
```

```
1: Problems with 3 or more ADL's.
2: 1 or more patient behavior or cognitive problem.
3: Expected life limit of less than 6 months.
4: Combination of the following:
   2 or more ADL dependencies
   <AND> 2 or more of the following:
         Problems with 3 or more IADL's
     <OR> age of patients is 75 or more.
     <OR> living alone in the community.
     <OR> utilizes the clinics 12 or more time in the
          preceding 12 months.
Enter RETURN to continue or '^' to exit:
```

Example: National Data Report

```
673,7,ADHC,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,8,ADHC,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,9,ADHC,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,7,CC,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,8,CC,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,9,CC,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,7,HHHA,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,8,HHHA,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,9,HHHA,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,7,VAIHR,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,8,VAIHR,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0
673,9,VAIHR,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0,0

   The above information is Geriatric Extended Care "Home" Referral data from
TAMPA VAMC #673 for Fiscal Quarter # 4 of 2008. (Calendar Quarter 3)
-------------------------------------------------
   Each section of data is separated by a comma. The table below defines the
sections. Numbers represent Patients. Patient only counted once.

  1 Number for the site.
  2 Number that stands for the Month (1=January)...
  3 Acronym for the Program (ADHC,HHHA,VAIHR,CC)
  4 Total number of patients referred to the program that month
  5 Number that DID NOT MEET ANY of the criteria
  6 Number that only met criteria 1
  7 Number that only met criteria 2
  8 Number that only met criteria 3
  9 Number that only met criteria 4
 10 Number that only met both criteria's 1 and 2
 11 Number that only met both criteria's 1 and 3
 12 Number that only met both criteria's 1 and 4
 13 Number that only met both criteria's 2 and 3
 14 Number that only met both criteria's 2 and 4
 15 Number that only met both criteria's 3 and 4
 16 Number that only met the criteria's 1 and 2 and 3
 17 Number that only met the criteria's 1 and 2 and 4
 18 Number that only met the criteria's 1 and 3 and 4
 19 Number that only met the criteria's 2 and 3 and 4
 20 Number that met all criteria's, 1 and 2 and 3 and 4

-------------------------------------------------
The Basic Criteria for Eligibility is shown below.

 1: Problems with 3 or more ADL's.
 2: 1 or more patient behavior or cognitive problem.
 3: Expected life limit of less than 6 months.
```

```
4: Combination of the following:
     2 or more ADL dependencies.
     <AND> 2 or more of the following:
           problems with 3 or more IADL's.
     <OR> age of patients is 75 or more.
     <OR> living alone in the community.
     <OR> utilizes the clinics 12 or more times in the
          preceding 12 months.
```

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